STRAIGHT SALARY?
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the MODERN HOSPITAL

VOLUME 62 MAY 1944 NUMBER 5

Setting a True Course *for* Tomorrow

A Wartime Message to Gumpert's 50,000 Regular Customers

By S. Gumpert

PRESIDENT, S. GUMPERT CO., Inc.

A FLEETING break in the overcast, a mere flicker of sunlight, and the navigator's sextant fixes his ship's position and sets his course.

So, through the war-clouds, farseeing men sight the gleam of a bright tomorrow, and chart a passage to the post-war world.

That V-Day toward which we are all striving will not find Gumpert unready. Even in the thick of the struggle to produce in record volume for wartime demands, special Gumpert research experts are steadily perfecting new ideas, new methods, new products for your post-war business. Many of these are "set to go," more are being readied as each month passes.

Today's objective is war, on its bitterest, broadest scale. In that grim task none dares relax for a single instant. But there *is* a tomorrow on the business chart—a day of new opportunity for you and for Gumpert.

For that day Gumpert will be prepared.

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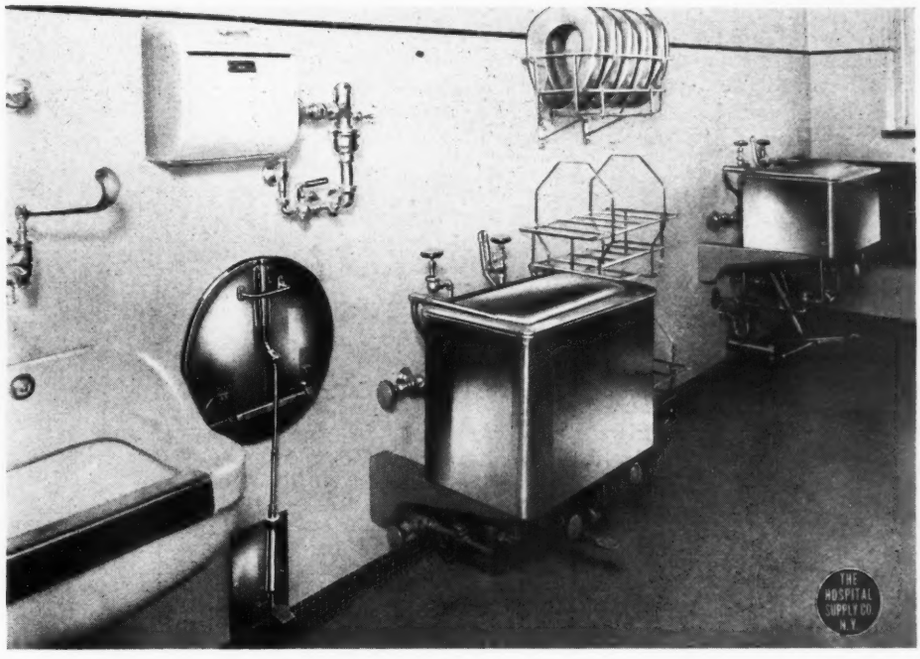
ORBIT BEDPAN WASHERS and STERILIZERS NOW AVAILABLE...

Orbit Empties and Cleans a Bedpan in less than a minute

1. Press pedal with foot. Cover automatically drops to form a shelf.

2. Set bedpan on the shelf; no reaching. No springs or clamps to bother with.

3. Close cover which automatically empties bedpan. Press valve handle; pan and hopper are washed perfectly clean, automatically, in less than a minute.



"Orbit", the original Bedpan Washer of modern design, empties and washes a bedpan clean, in less than a minute, in a closed hopper, without splashing, without odors and without soiling nurses' clothing. Made in built-in and exposed models.

Companion to the Orbit Washer is the Orbit Sterilizer pictured in the center above, which sterilizes five bedpans at a time. Then pans are lifted out in the Orbit Rack and placed where they are handy when needed.

This Orbit equipment speeds and streamlines utility room work and is widely used in hospitals throughout the country. An installation in a large New York hospital is shown above.

Now that war demands have been largely met, Orbit Washers and Sterilizers are again available to civilian hospitals, on WPB approval. If you are modernizing or equipping a new hospital, be sure to investigate the advantages of Orbit equipment. Literature on request.

ORBIT

THE HOSPITAL SUPPLY CO.

MANUFACTURERS

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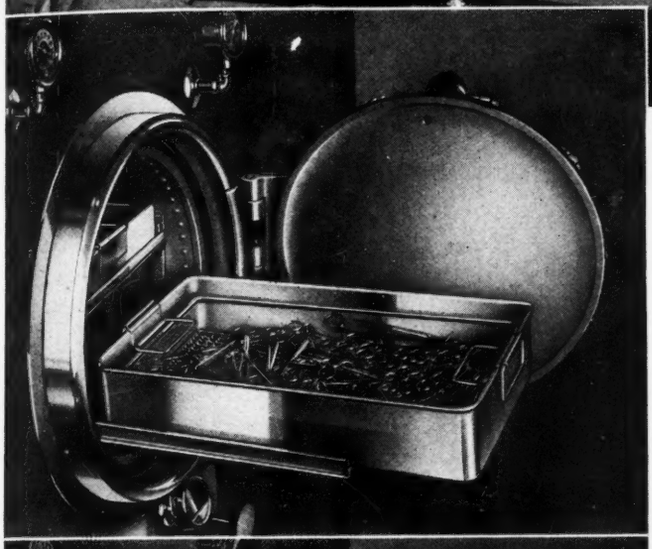

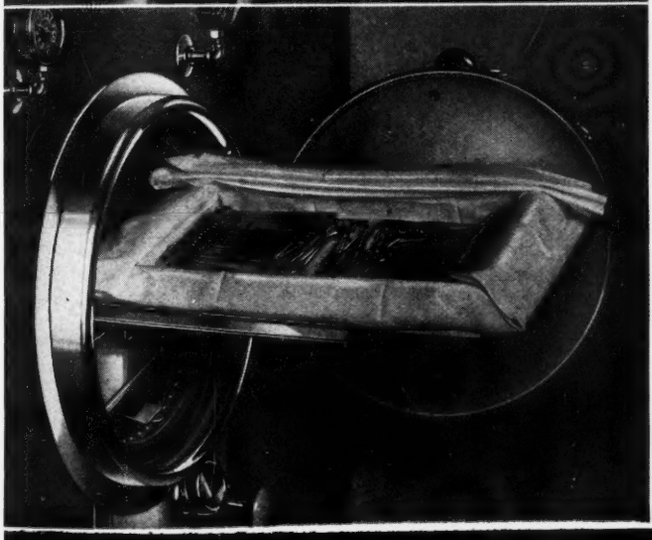

Time-Saving Techniques for Sterilizing Instruments

Autoclaving of instruments and utensils is preferred technique in many hospitals. It insures positive surgical sterilization in less time. It eliminates formation of scale on instruments and utensils. It permits the instruments and utensils to be removed from the autoclave practically dry. When equipped with the slide-a-way tray equipment illustrated at left, the autoclave is ideal for washing and sterilizing septic instruments.

Detailed information concerning modern sterilizing equipment will be supplied on request.

THE ROVING REPORTER

Exhibit of Skill

In Jackson Park, Chicago, stands the Museum of Science and Industry, a classic structure dating back to the World's Fair of 1893 when it served as the fine arts building.

Newly installed in this building of fascinating exhibits is a permanent Office of Civilian Defense display portraying the functions and accomplishments of civilian defense workers during this war period. Crowds of people cluster around this huge exhibit (it occupies 20,000 square feet) for it is three dimensional and is animated by light, color and sound.

You would be particularly drawn to the medical booth, executed by Alexian Brothers' Hospital, Chicago. The honor of preparing this booth went to the reverend Brothers because theirs was the first institution in metropolitan Chicago to organize a medical field unit.

It was well that the job fell to the Brothers for they had the time, the talent and the patience to build and paint the miniature community being protected by their medical field unit. In the scale of ⅛ inch to the foot, the Brothers built a five unit war plant, their hospital, church and school, a warehouse, an administration building, garages and 12 workers' homes.

This tiny community is peopled by 30 doctors, nurses, workmen and others and there are street lights, telegraph poles, trucks, ambulances, motor cars, water tank, trees and shrubs. It took Brother Claude and artist Lucian Lupinski of the hospital staff 550 hours to prepare the exhibit.

For Better Staff Meetings

It's a truism that a hospital gets out of its staff conferences just about what it puts into them. A convenient and well-equipped conference room usually has a stimulating effect on attendance and even upon presentations.

Rochester General's staff conferences have been mentioned on this page before now. You may remember references to the Harry D. Clough prize for house officers and the outline for conference case presentations. We're back at a Rochester General staff conference once again for a look-see.

Isn't that handsome lectern something new? The old "music stand" has disappeared, sure enough, and in its place stands a replica of the lectern at the Rochester Academy of Medicine complete with Aesculapian serpent and staff.

Those color slides of tissues certainly have depth and clarity of detail. The

THE MOST POPULAR SHOW IN TOWN

Federal Works Agency

It lasts only fifteen minutes each day but no other exhibit can compete with it in emotional intensity. The nursery at the new Arlington Hospital, Arlington, Va., has the hours plainly marked on the viewing window.

Sulfa Drugs

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Every hospital pharmacist who strives to serve adequately the drug requirements of his staff maintains representative stocks of Lilly sulfa drugs in all the forms and sizes. Sulfa drugs know no season, are in steady demand throughout the year. Sulfa drugs bearing the Lilly Label are characterized by uniformity in appearance, accuracy of dosage, rapidity of disintegration, and by their dependable therapeutic value.

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improvement, we learn, isn't in the photography, which was always good, but because they are projected on a new beaded glass screen.

The statistical slides are simpler to comprehend because the staff man reporting his research on the case is proudly wielding the new flashlight spot pointer.

Behind the stunning new draperies at the windows are new dark shades that really exclude the light.

There is no more "Next slide, please" interruptions via telephone to the projection booth because the speaker now has a silent push-button signal. Nor does the projectionist wear an overcoat and blow on his hands between slides for a radiator has been installed in the booth.

Doctors are not called out of staff conference except on urgent need. Telephone messages are taken, posted on the bulletin board just inside the conference room entrance and staff men check up at the board before leaving the room.

No wonder the conference runs so smoothly. Rochester General's custom has been to serve luncheon immediately following staff conference but the men were getting a little leary about the luncheon as new reports of help shortages, aggravated by an epidemic, met their ears. But the dietitian is determined to continue the luncheons and many extra hours of labor are willingly put in so that the doctors may be physically, as well as professionally, nourished at conference time.

Britons to the Rescue

Reverse lend-lease operated happily at Grasslands Hospital, Valhalla, N. Y., when during March a British hospital unit of 16 members signed away three weeks of shore leave to lend their services to the Westchester County institution on whose present staff there are 150 vacancies.

Wing Commander R. W. Durand of the medical division of the Royal Air Force thinks his group the first British medical unit to volunteer for civilian medical duty in this country. His men are British Army and R.A.F. laboratory technicians, pharmacists and orderlies with one Army nurse. Wing Commander Durand is a former London physician.

The ship on which the unit was serving was docked for repairs for three weeks. The group had been on sea duty for many months with seldom any time for a breather on deck. Their regular periods of twelve hour duty were often stretched to fifteen and sixteen hours, so an ordinary day's work in the beautiful Westchester County countryside was something of a vacation to them.

Dr. E. L. Harmon, director of Grasslands, says the aid given was "manna from heaven."

Boards to the Recue

Did we report the fact that board members at Michael Reese Hospital, Chicago, have been doing the high dusting, repairs and general flunky work about the institution? At least, they started doing it but, being executives, they soon had other men volunteers reporting for hospital duty three evenings a week and on Saturday.

At Children's Memorial Hospital, Chicago, some of the woman's board members took over laundry duties late in March when the labor supply ran hazardously low and the work was four days behind schedule. Working efficiently by their side was Mabel Binner, the superintendent; they did sorting, ironing and folding.

Women auxiliary members at Evanston Hospital, Evanston, Ill., in a similar emergency took their places at washers, driers and ironers, showing up on regular shifts for several days. With them worked anesthetists off duty and a member of the accounting staff. Here's how the *Pilot* editor reports the return to normalcy:

"Patients and staff members can now remain in their gleaming whites. The accountant is back at his accounting. The

anesthetists are back in the operating room and the North Shore ladies are back on the North Shore waiting for the next emergency to arise—and probably hoping that it won't be in the boiler room."

But what are state hospitals to do with no local board of trustees or women's auxiliary to step in? Take the whisker situation in Illinois state institutions. Because of the shortage of barbers the 20,000 male residents in hospitals and other state institutions get shaves only once a week and a hair cut only once a month. The prewar schedule was a shave three times a week and a haircut once a week.

Newton's New Publications

Newton Hospital now comes along with two more booklets—one addressed to the general public, the other to patients.

The patients' booklet is the more attractive of the two, or maybe we're just prejudiced. Called "Getting Well at Newton Hospital," its cover is a replica of The MODERN HOSPITAL cover for October; you remember, the graduate and student nurse in profile against an anatomical chart. It was photographed at Wesley Hospital, Chicago, by Russell T. Sanford of our staff, but the girls were professional models, not nurses. The Wesley girls are pretty, too, but very busy these days.

Getting back to Newton Lower Falls 62, Mass., the new guest booklet tells patients about preliminary arrangements, types of accommodations, what personal belongings to bring to the hospital, admitting procedures, nursing service, meals, noise problems, smoking regulations, visiting hours, flowers and other gifts, the coffee shop, telephone inquiries, radios, reading materials, chaplaincy service, barbering, physical therapy, checking out and opportunities to comment on the service and to serve the hospital after leaving. There are many fine illustrations, ruled pages for listing gifts and flowers received and for diary notations. And, in the front, there is a plug for the other booklet, which may be had by any patient on request.

Nice going, Gerhard Hartman!

A.W.V.S. Honors Volunteers

A mimeographed monthly for its volunteers appeared for the first time in March at Wesley Hospital, Chicago. The editing is done by the two members of American Women's Voluntary Services as a tribute to the women of various groups who gave 63,396 hours to the hospital in 1943 and who are hanging up a new record for 1944. Largely inspirational in character, the first issue contained a bit of news that may interest other large cities. Directors of volunteer services in the Chicago metropolitan area are meeting together monthly to exchange ideas and they will set up and man a consultation booth on volunteer service at the Tri-State meeting.

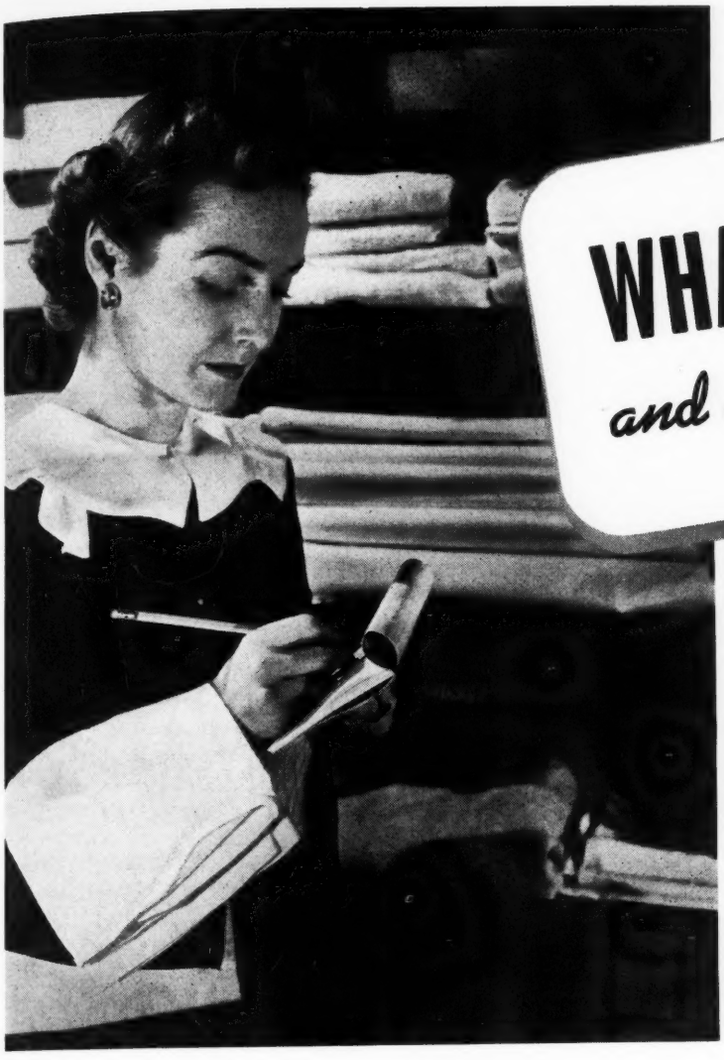
They Take Up Their Beds

Many months ago your Roving Reporter made mention of the convenience to citizens of Berkeley, Calif., afforded by the rental service for sickroom supplies inaugurated by Berkeley Hospital. This good-will and public health gesture is paying even more tangible dividends in these overcrowded war days.

Recently, Berkeley Hospital bought 20 more hospital beds for rental purposes and with the prospect of easier and more efficient home care the less acutely ill patients are encouraged to set up hospital facilities in their own homes so that new patients can be hospitalized.

Pins for the "Regulars"

When an employe completes five, ten, fifteen or twenty years of service at Rochester General Hospital, Rochester, N. Y., he gets a pin with chevrons indicating length of service. As a new five year anniversary comes around, he turns in his old silver pin for a new one. The twenty year gold pins are never given up. Any employe who resigns may keep the pin he is then wearing.



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READER OPINION

Surgeons, Too

Sirs:

With regard to your editorial "An Intemperate Demand" in the March issue of The Modern Hospital:

Radiologists do not object to being paid a salary if, as and when the surgeons, obstetricians and gynecologists and various medical specialists in their institutions are paid on the same basis.

Your editorial would place radiologists in a distinguished category which includes deans of medical schools, editors of medical journals, teachers and health officers. None of the ones whom you mention, however, is engaged in examining and treating patients. Radiologists are. The radiologist only asks to be treated as other staff doctors and not as deans, teachers or health officers.

If hospitals will always consider the radiologist as entitled to the same arrangements as their other staff physicians and surgeons, there will be no difficulty.

Karl J. Myers, M.D.
Myers Clinic
Phillipi, W. Va.

If radiologists are "entitled to the same arrangements as other staff physicians and surgeons," this would mean that the radiologic department would be open to use by any qualified radiologist of the community.

Presumably, the radiologist could reserve the use of a particular machine for a certain period. He would send his own bill to the patient and make his own collections. He would take his turn in serving free patients along with the other radiologists. Patients could select whatever radiologist they wished among those who had been accepted by the hospital for staff positions.

Such an arrangement would bring many headaches to hospital administrators. Would it have compensating advantages to radiologists?

For a further discussion of this question, see the article by Robert N. Brough on page 51 of this issue.—Ed.

It Is Intemperate

Sirs:

I appreciated and enjoyed the editorial entitled "An Intemperate Demand." The radiologists' claim of loss of dignity of their profession by a salary arrangement seems utterly ridiculous. We have one of the radicals in our town and I will be pleased when there is a return from the war of trained personnel so that we will be able to make a change. Our man is very insistent that every doctor control his patients to the extent that no out-patient or ambulatory patient be permitted to receive deep therapy treatment in the hospital but be taken to his office for such treatment. So far the medical profession lines up with him although the doctors advised the hospital to purchase and install the equipment which, to date, is running at a loss. Do you have reports on any such situations?

M. R.

Trustees Would Miss Them

Sirs:

I can truthfully say that the distribution of Trustee Forum reprints has been a successful venture at the Mercer Hospital. The reading of these articles has definitely broadened the perspective of the active members of our board and I am sure that the interest manifested in the discussions, which have spontaneously resulted from the reading of this literature, indicates a development of the social significance of their responsibility as hospital directors.

George H. Buck
Superintendent
The Mercer Hospital
Trenton, N. J.

California Nurses' Salaries

Sirs:

While reading the March issue, I came across the editorial on nurses' salaries and realized that I am not familiar with General Order 26 or the California nurses' scale. Will you give me information?

Sister Anna L. Haug
Superintendent of Nurses
Bethany Deaconess Hospital
Brooklyn, N. Y.

General Order 26 of the War Labor Board, as amended on Jan. 12, 1944, exempts nonprofit hospitals from the necessity of filing applications for approval of wage and salary adjustments of their employes who are within W.L.B. jurisdiction. Such hospitals are expected to observe the policy of wage stabilization. But the regional boards may recommend to the national board that exceptions be made to the provisions of this order as may be necessary "to effectuate the wage and salary stabilization policies" of W.L.B.

Under this exception it would be possible for other regional boards to adopt schedules for pay for hospital nurses similar to the one adopted for California nurses. This schedule was presented in the November issue of The Modern Hospital, page 124.—Ed.

SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; William J. Donnelly, Greenwich Hospital, Greenwich, Conn., and others

Case for Isolation

Question: When a patient is brought to a small general hospital from another town and from a home in which this patient and three others were quarantined for scarlet fever, should that patient be admitted to the main building when there is an isolation building for such cases? There was a change of doctors and the new doctor had not seen the patient prior to her admission but was much annoyed that she had been placed in isolation quarters. He thought she should have been put in the main building until after he had made his diagnosis. There were no other patients in isolation at the time. When the patient's relatives telephoned the admitting office at the hospital they said they were bringing in a girl who had been ill for two weeks with scarlet fever.—C.K., Iowa.

ANSWER: The fact that this patient came from a home where three other persons were quarantined for scarlet fever is basis enough for the hospital to place the patient in isolation quarters until such time as a careful examination of the skin for evidence of peeling and a bacteriological examination of the throat could be made to determine whether the patient was a carrier of hemolytic streptococcus germs that cause scarlet fever. This isolation is also required by communicable disease control laws in all states.

Scarlet fever is an air-borne disease and patients such as the one described have, to my knowledge, caused outbreaks of scarlet fever in pediatric, surgical and obstetrical wards. No harm was done to this patient by placing her in isolation until a diagnosis was made and it was of great benefit to other patients to keep her isolated.—E. A. PISZCZEK, M.D.

Nurses for Eight Hour Shift

Question: How many more nurses are needed to carry on "straight shift" eight hour duty when changing over from twelve hours with two hours off in the afternoon each week and two whole days off per month? The new plan proposed and hoped for is a six day week with the twenty-four hours divided into three shifts: 7 a.m. to 3 p.m.; 3 p.m. to 11 p.m., and 11 p.m. to 7 a.m., with a relief nurse for the 11 to 7 shift. We now have nine nurses, three on first floor, three on second and three on night duty with outside nurse to relieve the night nurses each of whom receives one night off per week. —L.A.S., Mass.

ANSWER: You may change to eight hour "straight shift" duty and a six day week with little interruption in your present program, by adding one nurse to your present staff on a permanent basis, and continuing to use a relief nurse two nights a week for the 11 p.m. to 7 a.m shift. The following is offered as a suggestion: 7 a.m. to 3 p.m., five nurses; 3 p.m. to 11 p.m., three nurses; 11 p.m. to 7 a.m., two nurses.

In this way you will always have two nurses on each floor when the nursing load is usually heaviest. Two days each week you will have a "floater" who may be assigned duties where her services are most needed. Not knowing the number of patients, or subsidiary workers, this suggestion is offered only as a working basis.—MRS. JEWELL W. THRASHER.

Keep Bedside Records

Question: Is it the practice in a majority of hospitals to use bedside or nurses' records? If so, are they preserved after the patient is discharged and filed with the rest of the chart?—C.J.G., N. C.

ANSWER: It is believed that a majority of the hospitals approved by the American College of Surgeons use bedside or nurses' records and they are preserved after the patient is discharged and filed with the rest of the chart. In our institution these records have been kept for a period of twenty-five years and are filed numerically in a fireproof vault, accessible to but separate and apart from the institution.—A. A. AITA.

Books on Dietetics

Question: Will you please give me a list of the best books that are used by the best dietitians throughout the country.—H.G.J., N. Y.

ANSWER: The following books are from a list furnished by the American Dietetic Association:

"Treatment by Diet." Clifford Barborka. J. B. Lippincott, Philadelphia. Pp. 615. $5.

"Nutrition and Diet in Health and Disease." Dr. James S. McLester. Third Edition, W. B. Saunders Company, Philadelphia. Pp. 838. $8.

"Nutrition and Physical Fitness." L. Jean Bogert. Third Edition, W. B. Saunders Company, Philadelphia. Pp. 561. $3.

"Pediatric Dietetics." N. Thomas Saxl. Lea and Febiger, Philadelphia, 1937. Pp. 565. $7.

"Dietetics for the Clinician." Milton Bridges. Third Edition, Lea and Febiger, Philadelphia. Pp. 1055. $10.

"Applied Dietetics." Frances Stern. Williams and Wilkins Company, Baltimore, 1936. Pp. 263. $3.50.

"Dietetics Simplified." Jean Bogert and Mame Porter. Macmillan Company, New York, 1937. Pp. 637. $3.

"Nutrition in Health and Disease." Lenna F. Cooper, Edith Barber and Helen Mitchell. J. B. Lippincott Company, Philadelphia, 1938. Pp. 708. $3.

"Chemistry of Food and Nutrition." Henry C. Sherman. Fifth Edition, Macmillan Company, New York. Pp. 640. $3.

"The Foundations of Nutrition." Mary Swartz Rose. Third Edition, Macmillan Company, New York. Pp. 625. $3.50.

"Food in Health and Disease." Katherine Mitchell. F. A. Davis Company, Philadelphia.

"The School Cafeteria." Mary DeGarmo Bryan. F. S. Crofts and Company, 1936.

"Food Service in Institutions." Bessie B. West and LeVelle Wood. John Wiley and Sons, Inc., 1938.

Discounts for the Clergy

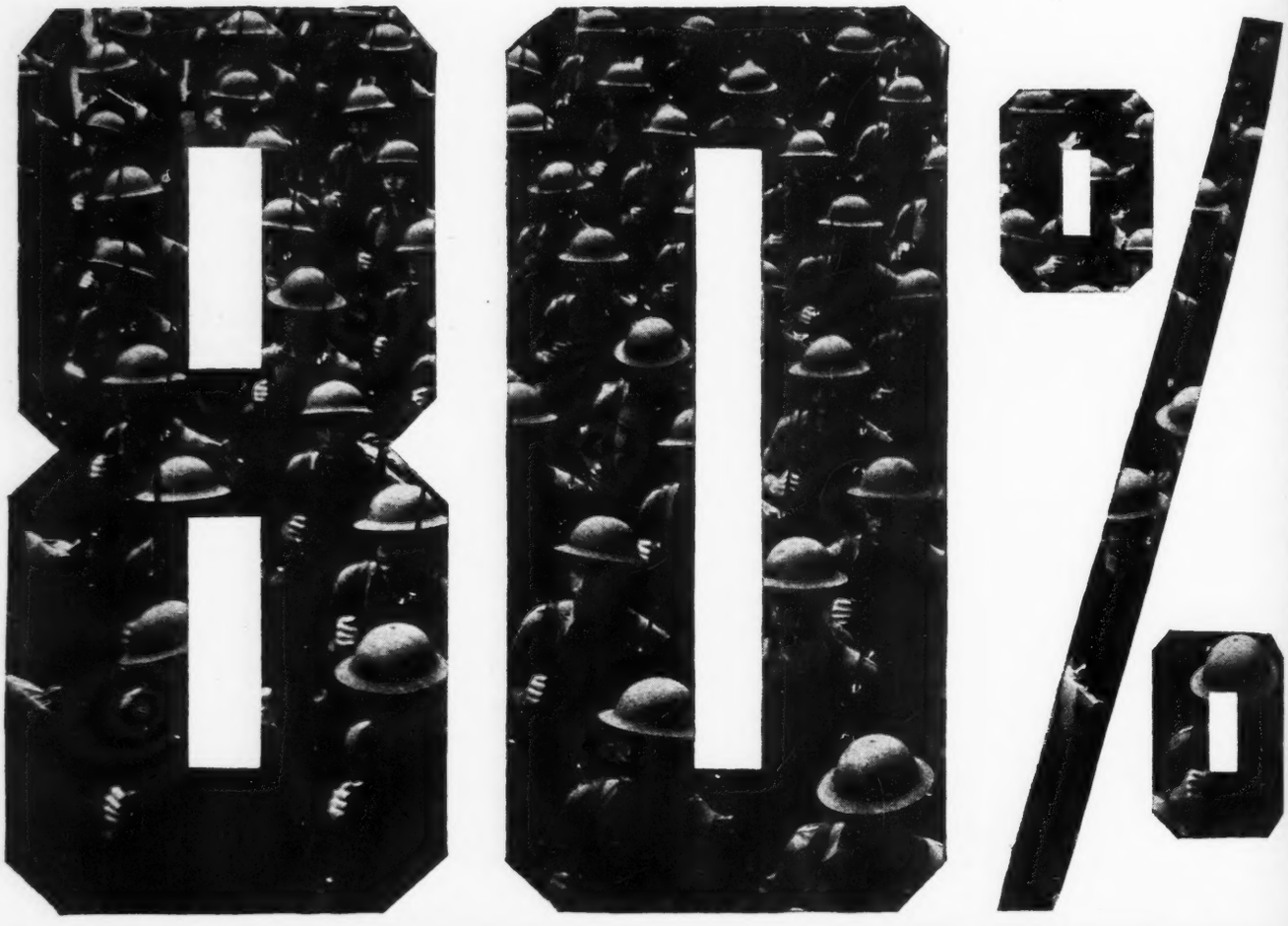
Question: Do hospitals as a rule allow ministers and their families a discount?—E.M.H., N. C.

ANSWER: Most of the ministers and their families in this area are covered by the Blue Cross plan and in this instance we place the patient in a private room accommodation for which we make no additional charge. We make approximately a 20 per cent deduction on extra charges to these members of the Blue Cross plan. In the case of a minister who is not a member of the Blue Cross plan but instead receives some benefits from the ministerial association, we give approximately a 20 per cent discount depending upon the case.—A. A. AITA.

Keep Aides Out of Nursery

Question: Should nurse's aides be excluded from the nursery when they are being taught routine procedures before being assigned for nursery duty? We average from 15 to 25 babies at a time in the nursery and the patients' rooms are some distance from the nursery.—F.C., N. C.

ANSWER: It is wiser to exclude nurse's aides from the nursery. After sufficient training has been given that their mastery of technic is assured, and if trained nurses are not available, a sufficient number may be assigned. The principle of having the smallest number of persons compatible with efficient work in the nursery should always be remembered.—W. C. DANFORTH, M.D.



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LOOKING FORWARD

Blue Cross for the Farmer

MUCH talk has swirled around the need for more Blue Cross enrollment in rural areas. Some good work in the field has already been done, as evidenced by Virginia Liebeler's article in The Modern Hospital for February and data from other areas. But, in general, rural enrollment has progressed very slowly.

It would be opportune for the Hospital Service Plan Commission to employ immediately the most successful rural enrollment specialist in the country and to make his services available as a consultant to every plan that covers a substantial rural area. Such a specialist could also make contacts with the American Farm Bureau, the Grange, the National Farmers' Union, the Farm Security Administration, farm magazines and radio stations, the Farm Foundation, agricultural extension agents, rural women's groups and others who lead or influence farmers' opinions and actions.

If every Blue Cross plan had immediate access to the best practices now available for the enrollment of farmers and residents of small towns, there should soon be a rapid increase in rural enrollment. Then truly "Blue Cross would come to rural America."

Texas Steps Out

THE eyes of the nation's voluntary hospitals may well center for the next year on Texas. Thoroughly aroused by the possibility of a federal plan of compulsory hospital and medical care insurance, the Texas hospitals have organized to see how far they can go on a voluntary basis when everybody puts his shoulder to the wheel.

A commission on hospital service plans will put drive and enthusiasm into the attempt to increase the Blue Cross enrollment in Texas from 100,000 to 300,000 during this year. With the whole-hearted support of Texas hospitals, this should not be an impossible goal in a state with 6,500,000 people.

Dr. Robert H. Bishop, chairman of the A.H.A. approval committee, believes that by such efforts as this the rate of net growth of plans can be stepped up from 2 per cent of the population per year to 5 per cent or better and held there for some years to come. He has suggested 15 steps to achieve this goal. The most important of these is the whole-hearted support by local hospitals, as has been pledged by the Texas Hospital Association.

Other important steps include the consolidation of weaker plans, wider use of the uniform national contract, more reciprocity, extension to small groups and to farmers, reduction of administrative expense to about 5 per cent and development of companion medical plans.

Pay for Senior Cadets

CONSIDERABLE distress is being evidenced by many civilian hospitals over the proposal to pay salaries of $60 per month plus maintenance to senior cadet nurses who serve in federal hospitals. The civilian hospitals that entered the cadet nurse corps program knew, of course, that the program required them to pay senior cadets at least $30 per month. Many hospitals apparently believed that this minimum was also to be the accepted general level.

In recruiting senior cadets from civilian hospitals, the federal nursing services have many emotional advantages. There are thrill and glory to federal service that alone will be sufficient to attract many senior cadets, especially to Army and Navy hospitals. When to this is added a $30 per month pay differential, the civilian hospitals believe that they may well be stripped below the 50 per cent minimum that they have been assured.

Who is going to stand as a policeman to see that not more than 50 per cent of the senior cadets leave the hospital in which they trained? What effect on the students' morale will result when the 50 per cent have gone and the remaining 50 per cent are told that they cannot go?

Of course, the civilian hospitals can also raise their pay to the $60 level. If they do, will the government then jump to $75 or $90 or $100? In a salary race, no civilian hospital can compete with the long purse of Uncle Sam.

While no one will deny the desirability of paying graduate nurses adequately for their services, the point

at issue here concerns students, for this period of service is necessary in most states before senior cadets can be licensed. Until the cadet nurse program was started, the student nurses served without pay in most hospitals and in the better institutions they paid tuition.

Would it not be better for all concerned for the federal nursing services to rely upon their prestige and glamour to recruit enough senior cadets to meet their essential needs? Civilian hospitals, too, occupy a crucial place in the nation's war effort.

Hospital administrators and directors of schools of nursing will read with interest and some reassurance Surgeon General Parran's statement on page 67 outlining various facts on the senior cadet situation.

Rotation of Office

WHEN the amendments to the American Hospital Association by-laws were presented at the Buffalo convention, the committee on by-laws presented an adverse report on the fifth amendment. This amendment would limit to two consecutive three year terms the length of office of trustees, members of councils and members of the hospital service plan commission. After a lapse of one year a member could again be reelected or reappointed as a trustee or council member.

The committee on by-laws opposed this primarily because it believed that it would "present the complication of having to elect a new treasurer each two years" and because "during the present national emergency it would appear to be the part of wisdom to retain in office those individuals who by training and experience have demonstrated their aptitude to deal with important questions and ably to represent the association."

During the discussion, however, the legal counsel of the association ruled that this amendment did not require the selection of a new treasurer each two years. So that argument drops out of the picture.

When this amendment was presented to the assembly, the vote was 130 in favor of the amendment and 72 against. Since a two thirds majority is required to pass an amendment, it failed. But the vote indicates quite clearly the desires of a substantial majority of the membership.

There appears to be no reason why the officers and trustees of the association might not have a six year limit put upon their terms. There should be, and apparently are, enough people in the association who are familiar with its activities and have the strong character and high principles that qualify them for service as trustees.

As regards the councils and the commission, however, the situation is a little different. They stimulate and direct the long-range thinking and research activities of the association. The chairmen of the various councils sitting as the coordinating committee constitute the "cabinet" of the president.

It is desirable that considerable continuity should characterize the councils, particularly those that have many interrelationships with other organizations. The present arrangement gives to the president a seasoned and experienced group of advisers, yet it keeps final control of the affairs of the association in the hands of the trustees. Even under the present arrangement, however, there is considerable turnover in council membership each year so that new people are constantly having the opportunity to gain experience in association affairs.

To make the association alive and vital, many members should take an active part in its work. But with eight councils, each of them with many committees, with a score or more of standing committees not appointed by the councils and with several positions open each year in the board of trustees, there should be no difficulty in finding a suitable outlet for the energies of any able hospital administrator in the United States or Canada who is willing to serve in association activities.

Medical Care Plans

TEN Blue Cross plans reported at the recent Detroit conference that they hope to start some kind of medical or surgical plans before the end of 1944. Some of these will doubtless be worked out in cooperation with local medical societies on a service basis. This is the most desirable form if the medical groups will cooperate wholeheartedly to make it a genuine public service. Other plans will provide a cash indemnity service, either through an insurance organization that they will set up or through contracts with an existing commercial company.

The interest on the part of Blue Cross executives in providing some kind of package plan to their subscribers is merely a reflection of the strong and growing desire of these subscribers for an opportunity to budget medical as well as hospital bills. It is a demand that will not down. The sooner it is effectively met, the better it will be for hospitals and physicians. It is encouraging that more and more physicians are anxious to assist in making such plans available on a comprehensive and reasonable cost basis.

Emily Post *v.* Marvin Jones

DAINTY table manners should be "out" for the duration. They waste too much food, in the opinion of Marvin Jones, War Foods Administrator. He believes that about 20 per cent of the nation's food is wasted, amounting to 225 pounds per person annually.

"Sop up the gravy and squeeze the grapefruit dry; pick up the bones in your fingers to get all the meat there is, and tip the soup bowl to get the last spoonful." Such is the edict of our new social arbiter.

HEADLINE NEWS

Extra Rations Allowed in Specified Illnesses; Pregnancy Is Included

WASHINGTON, D. C.—Individuals suffering from certain illnesses will receive additional food rations on the basis of needs for ten week periods, O.P.A. set forth in an amendment April 1 to G.R.O. 13.

To make sure that ill persons quickly receive such extra amounts of rationed foods as they may need, special treatment will be given applications for extra rations where the individual is suffering from an illness requiring additional amounts of certain foods.

Illnesses that automatically make a person eligible for more food were determined for O.P.A. by the medical food requirements subcommittee of the National Research Council. Heretofore, anyone whose health required more rationed food than the regular ration provides could request his local board to issue a supplemental ration, a procedure that proved to be unsatisfactory.

Active tuberculosis, diabetes mellitus, chronic nephritis and cirrhosis of the liver are among the numerous illnesses listed. Pregnancy is also listed.

When a supplemental ration is requested for an illness or condition of health other than those specified, the local board will act upon the application only in cases of emergency. All others will be sent to the district office for action. All applications should contain a written statement signed by a doctor, which gives a diagnosis of the applicant's illness as well as an estimate of the amount and type of rationed food required for the following ten weeks. In cases of pregnancy, this statement may be prepared by a public health nurse.

Wanted: Business Manager

A new position as business manager carrying a salary of $7800 to $9600 with $1000 additional for overtime has been created by the Wayne County Civil Service Commission for Eloise Hospital, Detroit. The business manager will have coordinate authority with the medical superintendent and is to be selected on the basis of a nation-wide examination. Applications may be made by a letter to the commission at 2200 Barlum Tower and must be mailed by May 15 to be considered. The maximum salary will be reached at the end of five years.

O.V.R. Outlines Policies, Recommends Cost Basis for Reimbursing Hospitals

By EVA ADAMS CROSS
Washington Representative, The MODERN HOSPITAL

WASHINGTON, D. C.—The section on "Requirements and Recommendations for Physical Restoration Services" of the manual of policies recently prepared by the Office of Vocational Rehabilitation, F.S.A., for state boards of vocational education and state agencies for the blind makes a workable blueprint of procedure for hospitals, according to an official in the office of Dr. Dean A. Clark, chief medical officer, O.V.R., on April 11.

This section outlines the scope of physical restoration services, standards for physicians and other professional personnel and for hospitals providing service, and rates of remuneration to them.

Emphasis is laid on case-worker responsibility in obtaining necessary integration of the rehabilitative services for each individual through employing the aid of the technical staff of the agency. The plan of rehabilitation is outlined from the standpoint of the client's need and economic circumstances and it is explained that, usually, federal reimbursement is not conditioned on the establishment of financial need.

It is strongly recommended that each state, after consultation with appropriate professional groups, appoint a professional advisory committee to include representatives from medicine, public health, nursing, hospital administration, medical social work, physical therapy and occupational therapy. Medical specialties that are especially important in rehabilitation, such as orthopedics, tuberculosis, psychiatry, ophthalmology and otology, should be represented.

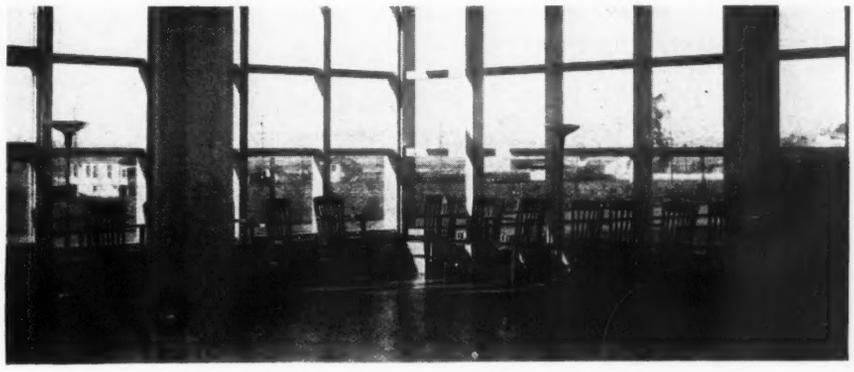
Physical restoration services should cover, when necessary, general medical treatment, specialist services, nursing, hospitalization, dentistry, drugs and supplies and prosthetic appliances.

Federal participation in the costs of hospitalization is limited to ninety days for the treatment of disabilities existing at the time physical restoration is undertaken. Federal funds are available for reimbursement for an additional ninety days of hospitalization for the same pa-

(Continued on Page 44)

Naval Hospitals to Expand

WASHINGTON, D. C.—The naval public works authorization bill became a law April 4. Projects sponsored by the bureau of medicine and surgery reach an estimated total of $42,071,750. It is anticipated that a total of 80,000 beds in naval hospitals will be required to meet hospitalization needs in 1945. Completion of the current 1944 public works program will make available 60,000 naval hospital beds.



VALLEJO COMMUNITY HOSPITAL

Waiting room of the new Vallejo Community Hospital, Vallejo, Calif., which was formally opened for the reception of patients on March 20. The one story structure was built with federal funds made available under the Lanham Act at a total cost of $1,325,000. The 250 bed hospital was designed by Douglas D. Stone, hospital architect, San Francisco.

tient only if further treatment is undertaken to correct a new disability.

In the selection of hospitals, it is desirable to give preference to those larger than 100 beds with well-developed surgical and specialty services, medical social service, physical therapy and occupational therapy departments, the manual states. When practicable, preference should be given to hospitals that afford residency training in the specialty required for treatment of the patient.

In approving state standards for hospitals, O.V.R. will for the present be guided by the list of hospitals approved by the A.C.S. In selecting hospitals for specialty services, state agencies are referred to hospitals approved by the A.M.A. for residency training in the specialties.

In paying hospitals, each state shall establish a schedule or standards for the determination of the per diem rates. When the rate is on a cost basis, the state plan shall utilize the method approved by O.V.R. for the computation of costs of inclusive service in minimum accommodations as set forth in the circular, "Purchase of Hospital Care." Inclusive rates may vary with the locality or for the particular hospital, but no schedule may establish rates that exceed the average daily costs as computed in accordance with the method approved by O.V.R.

Services Included in Rates

Per diem rates for hospital care shall include: bed and board in ordinary nonluxury accommodations; general nursing; drugs and supplies; casts; all other inpatient care, including the use of operating rooms, laboratory, x-ray, anesthesia; physical therapy; occupational therapy, and other services rendered by individuals who receive any remuneration from the hospital for such service.

The state plan shall indicate how to determine the reasonable cost of such items as blood donors, x-ray, anesthesia, special nursing, appliances and casts and drugs and supplies not provided by the hospital and therefore not covered by the inclusive rates.

Pending the establishment of maximum rates, federal reimbursement will be available with respect to costs of authorized hospital care provided in accordance with the state plan. It is strongly recommended that care be purchased from public and voluntary hospitals at inclusive per diem rates based on the costs of hospital services.

The suggested method of estimating reimbursable costs is essentially the same as that of the Children's Bureau. Its adoption by the state rehabilitation agencies will go far toward eliminating unnecessary duplication in auditing and cost reporting.

Hospital Section, W.P.B., Wins Fight Against Decentralization

WASHINGTON, D. C.—Although nearly all other types of W.P.B. applications were decentralized on April 8, the hospital section won its fight to keep control in Washington for all projects costing $25,000 or more, except that amendments to project authorizations increasing the cost to $25,000 or more may be processed in the field where the effect of such amendment, together with preceding amendments, if any, shall not be to increase the cost by more than 50 per cent of the original estimate. The same rule applies to laboratory facilities, as defined in order P-43. On most other types of projects the authority of the field offices includes projects up to $100,000.

Because of the highly specialized character of hospitals, it was considered simpler to have the majority of them processed in Washington where the staff is familiar with hospital problems.

War Department Refutes Story on Nonuse of Negro Nurses

By EVA ADAMS CROSS

WASHINGTON, D. C.—The War Department in a statement March 30 took issue with stories recently appearing in the press to the effect that it is not making maximum use of the services of available Negro nurses who are said to desire to enter military service as members of the Army Nurse Corps.

It is the policy of the War Department, the memorandum said, to assign Negro nurses to those hospitals in which there is a substantial number of Negro troops in relation to the personnel of the entire installation. Under this policy Negro nurses have been assigned to seven installations within the United States.

In determining the placement and use of these nurses, decisions have never been made from the standpoint of quotas, but rather from that of the particular needs as they arise in the over-all Army plans for allocation of troops.

Council Endorses $60 Minimum

Endorsement of uniform minimum pay of $60 a month for senior cadet nurses in the federal nursing services was recommended in a telegram to President Roosevelt by the National Nursing Council for War Service on March 17. The telegram mentioned that the council represented the various nursing organizations and the federal nursing services but did not mention hospitals.

More Doctors, Nurses Are Sorely Needed in Veterans' Hospitals

By EVA ADAMS CROSS

WASHINGTON, D. C.—With approximately 80,000 beds available for sick and wounded former servicemen, with 10,000 additional beds to be made available in the coming year, veterans' hospitals are in urgent need of doctors and nurses, said Dr. Charles M. Griffith, medical director of the Veterans' Administration, in a three-way interview April 11 with Gwen Andrew, superintendent of nurses of the Veterans' Administration, and the Washington correspondent of THE MODERN HOSPITAL.

The agency is already 600 doctors short. As for nurses, there are 800 vacancies; another twelve months will bring a requirement of a total of 8000 nurses, as compared with a present staff of 3900. And the peak is still to come.

What is the Veterans' Administration doing about it? Well, explained the medical director, it is using enlisted men —1620 of them—as hospital attendants; it has asked for 614 more. It has suffered a heavy loss of medical personnel to the armed forces. Now, however, General Hines, the administrator, has been given authority to commission doctors and thus retain them. He is seeking authority to commission nurses and dietitians as well.

Age limits in the acceptance of nurses have been waived for the duration, Miss Andrew pointed out. It is, however, necessary for the nurse applicant to meet physical requirements, to be a graduate of a recognized training school and to be a registered graduate nurse. Moreover, the Army and Navy have given 150 doctors to the Veterans' Administration where they are assigned to rating boards to expedite the clearance of applications for compensation of former servicemen and women.

Pending legislation will provide a half billion dollars for additional hospital facilities for the Veterans' Administration. Both Army and Navy hospital programs are coordinated and integrated with the war-time expansion of federal hospitals and over-all planning for postwar needs for hospitalization of veterans.

Hospitals Needn't File Tax Returns

Charitable organizations, if primarily supported by contributions of the general public or supported in whole or part by government funds, such as community chests, hospitals and homes for indigents, need not file tax returns on May 15, the commissioner of internal revenue has announced.

Quotas for Hospital Nursing Personnel Set Up as State Guides by P. & A. S.

WASHINGTON, D. C.—Definite quotas for nursing personnel in hospitals have been established by the directing board of Procurement and Assignment Service as a guide to state and local committees for nurses.

For day supervisors and head nurses together the ratios to patients are as follows: medical and surgical services, 1 to 15; obstetric service, mothers, 1 to 12, infants, 1 to 26; pediatric service, 1 to 12; for operating rooms, one to each 4.1 operations; for night supervisors on a forty-eight hour week to patients in the whole hospital, 1 to 80.

For graduates, students and auxiliary workers (excluding supervisors and head nurses), the following hours of nursing service per twenty-four hours are recommended: with all-graduate staff: medical and surgical, 2.7; obstetric, mothers, 3.7; infants, 2.1; pediatric, 3.4, and communicable disease, 4.0; with graduate and student staff, medical and surgical, 3.2; obstetric, mothers, 4.2, infants, 2.3; pediatric, 4.4, and communicable disease, 4.7.

With an all-graduate staff on a forty-eight hour week, one nurse to 1.2 operations is recommended, while with graduate and student staff with graduates on forty-eight hour week and students on forty-four hour week, one nurse to 1.0 operations is the ratio.

The part of the service rendered by graduate floor duty nurses in general hospitals with students should provide for a minimum of 0.5 hours per patient per twenty-four hours and a maximum of 1.0 hours, with the rest of the service provided by students and auxiliaries. In hospitals without students, the figures are raised to 1.5 and 2.5, respectively.

Translated in terms of staff required on a forty-eight hour week basis, these standards work out as follows in a general hospital with a daily average of 100 patients including newborn: 7.3 minimum average number of nurses and 14.6 maximum for the hospitals with students. Without students the numbers are 21.9 and 36.5, respectively. These figures apparently take account of sickness, vacation and other such factors.

Thirty-seven states are now ready to clear nurses under the procedure set up by P.&A.S.

Plan to Avoid Black Market in Penicillin for Civilian Use

WASHINGTON, D. C.—W.P.B.'s penicillin producers industry advisory committee is studying proposals for exchanging technical and patent information while members of a subcommittee are working on the civilian distribution job.

The subcommittee has been asked to make recommendations on how civilian distribution should be handled when penicillin is available to the extent of some 10,000,000,000 units or more a month.

A number of proposals for distribution were advanced for consideration. One of these was that allocation through the National Research Council would be continued for suitable critical cases in which there is jeopardy to life, for a limited number of serious but noncritical cases, and for research. Definite recommendations were considered premature at this time.

The outstanding suggestion was that until such time as more than 10,000,000,000 units are available, rigid control of civilian distribution would be necessary to prevent black market operations and indiscriminate use of penicillin.

Bolton Act Is Amended

WASHINGTON, D. C.—An amendment to the Bolton Act to correct a legal technicality was made March 29. The technicality excluded 142 student nurses enrolled in the cadet nurse corps in two federally operated hospitals in Washington—Freedmen's and St. Elizabeth's—from participation in the program. The contradictory status of the nurses developed out of a provision of the law that prohibits employes of one federal unit from participating in any other program operated by the federal government. The amendment made an exception in this case. Other amendments permit Army and Navy hospitals to participate in the cadet nurse corps training.

Navy Starts Rehabilitation Office

WASHINGTON, D. C.—The Surgeon General of the Navy has authorized the establishment of an Office of Rehabilitation to develop, place in operation and direct the program of rehabililtation for the medical department of the Navy. Rehabilitation, as it relates to this program, means all activities and services required to supplement the ordinary or usual therapeutic procedures in order to achieve maximum adjustment of the individual patient either for further military services or for return to civil life with the least possible handicap from his disability.

Three New Blue Cross Plans Organize in April; Connecticut Plans Merge

New Blue Cross plans were formed or in the process of forming last month in Florida, West Virginia and Indiana and the two approved plans in Connecticut merged into one state-wide plan.

Funds for initial capital had been pledged and paid in part to start the Florida plan and an office was to be opened in Jacksonville. H. A. Cross, formerly superintendent of the Good Samaritan Hospital, West Palm Beach, is to direct the new plan.

The West Virginia Hospital Service, Inc., was formed at Wheeling and started to sell contracts during April. It is designed to serve the entire state and the hospital people sponsoring it hope that existing local plans will affiliate. The director and secretary is William M. Morel and the president is a Wheeling attorney, Tom B. Foulk.

The new Indiana plan was formed under existing state laws. It expects to take over the business of an existing commercially sponsored plan in the state.

The Connecticut Plan for Hospital Care, with headquarters in New Haven, reported a total enrollment on April 1 of 362,500 persons while the Hospital Service Plan, Inc. of Norwalk had an enrollment of 27,279. Thus, the new state-wide Connecticut plan becomes the eleventh largest in the United States.

G. I. Bill of Rights Provides Additional Hospital Facilities

WASHINGTON, D. C.—The "Servicemen's Aid Act of 1944" introduced March 18 into the Senate carries an authorization for $500,000,000 for construction of additional hospital facilities.

Declaring the Veterans Administration to be an essential war agency and entitled, second only to the War and Navy departments, to priorities in personnel, equipment, supplies and material and in appointments of personnel from civil service registers, the bill grants the Administrator the same authority and discretion as the War and Navy departments and the U.S.P.H.S.

The Administrator of Veterans Affairs and the Federal Board of Hospitalization are directed in the bill to complete the construction of additional hospital facilities for war veterans and to enter into agreements and contracts for the use of suitable Army and Navy hospitals by the Veterans' Administration after cessation of hostilities and after such institutions are no longer needed by the armed services.

AIRPLANE VIEW—MARY HITCHCOCK MEMORIAL HOSPITAL

Group Practice Is One Answer

to the problem of distribution

JOHN P. BOWLER, M.D., and LESLIE K. SYCAMORE, M.D.
Hitchcock Clinic, Mary Hitchcock Memorial Hospital, Hanover, N. H.

IN THE last fifty years the economic aspects of medical practice have become vitally important and have been removed from the scope of individual adjustment to become the joint responsibility of society and of the medical and allied professions. The urgent need today is to develop mechanisms for making available to the individual patient the full resources that medical science has developed while preserving insofar as possible the proved values of the true professional relationship between physician and patient.

There are two requisites to the solution of this problem: on the one hand, adequate facilities for medical care must be reasonably available to all areas of our country and all segments of our population; on the other, these available facilities must not be denied to any individual because of their cost.

Adapted from the annual symposium, United Hospital Fund, New York City, March 1944.

Group practice is one mechanism that is making a definite contribution towards providing proper distribution of adequate medical care on an efficient basis and, therefore, at lowered cost. Such a form of organization can be developed most effectively around the hospital as a focal point. As an illustration of such a development, we shall proceed to an outline of our own hospital staff organization.

Mary Hitchcock Memorial Hospital is an institution of 200 beds, located in Hanover, N. H., the seat of Dartmouth College.* Hanover is a town of 3000 population to which the college community adds nearly an equal number. From early times Hanover has served as a medical center to the surrounding area.

The establishment of the Dartmouth Medical School in 1797 brought to the community Dr. Nathan Smith, the founder of the school; and then, in the century following, came a succession of prominent medical figures of those times, some as permanent residents, others as visiting lecturers for specialty courses. Although originally providing the full course in medicine, the Dartmouth Medical School discontinued in 1914 the clinical teaching of the last two years.

Largely through the influence of the medical school, Mary Hitchcock Memorial Hospital was erected by Hiram Hitchcock of Hanover and New York in 1893. Its original ca-

*"Health Center in the Hills," by Raymond P. Sloan, The MODERN HOSPITAL, April 1938.

pacity was 36 beds. Because of its relationship as the teaching hospital of the medical school, the institution has always functioned with a closed staff.

During the early years, while members of the professional staff of the hospital worked in excellent cooperation, only the ward patient received the benefit of the combined resources of the staff. Otherwise each member was independent, conducting his own practice, maintaining his own offices, providing his own equipment and looking after the business aspects of his calling.

There was a realization of the need and opportunity to effect a reorganization of the staff into a group clinic. Its members were convinced of the inadequacy of the individual doctor in the ever-increasing scope of the medical field, of the desirability of unified action in meeting the impending developments and problems of medical practice and of the necessity for correlated expansion of the hospital staff to cover the specialty fields.

At that time, nearly 20 years ago, there was almost a complete absence in that area of northern New England between Boston and Montreal of men of recognized specialty training in such fields as radiology, endoscopy, thoracic surgery, neurosurgery, plastic surgery, pediatrics and anesthesiology. This certainly represented unavailability of medical service to many patients.

Medical Center Organized

Essentially, this proposal meant the organization of a rural medical center with complete coordination of the participating factors, the hospital to be the physical hub of the wheel. The project met with the enthusiastic cooperation and interest of the board of trustees and has continued through the years as a thoroughly joint medical and lay effort.

No professional staff member is eligible to membership on the board of trustees, but actual and efficient liaison is accomplished by joint meetings of the staff board of governors (consisting of professional staff representatives), the executive committee of the board of trustees and the superintendent. All joint committees on policy, organization and administration are appointed by this group and the superintendent acts as executive secretary of these various committees as well as of all subcommittees of the professional staff.

In brief, the hospital and its functions are the joint interest of both bodies and to no physician is it merely a workshop in which he spends a certain portion of his time in his daily activities. Neither is the main interest of the superintendent and the executive committee of the board that of running a successful business venture irrespective of the tangible and intangible factors that influence its main function—that of medical service.

The hospital staff of five men was therefore organized as a group clinic in 1927. Since then there have been a steady growth in numbers and an increasing expansion of medical coverage. Three of the five founders are still in active practice and 17 men have been added in these last seventeen years. The full staff now includes qualified specialists in obstetrics, radiology, pediatrics, allergy, ophthalmology, otolaryngology, internal medicine, urologic, thoracic and plastic surgery, neurosurgery, neuropsychiatry and anesthesiology.

Several of the new specialty services were added with some doubt as to the reality of the need. In each case, the projected load was always greatly underestimated. As in many things, the need was made obvious as soon as the service was available.

Almost every variety of practice is within the activities of the group. There are no practicing physicians in the local community outside of the clinic. Therefore, its members are family physicians within the township. Ninety per cent of the hospital patients are referred cases from a large northern Connecticut River valley area and considerable consultation work is done throughout this area by the members of the clinic.

In addition, the clinic serves, under a contractual relationship, as the professional staff of the Dartmouth College health service. Utilizing Dick Hall's House, the college infirmary, which functions as a wing of the hospital, the health service supplies complete medical and surgical care and hospitalization to the student body of Dartmouth College.

Many assets accrue to the doctor as a result of group organization of medical practice. Each physician finds constant professional stimulation in the interplay of thought and experience among the various members of the group. In the solution of any specific diagnostic or therapeutic problem, the inevitably circumscribed skill of the individual is supplemented by the knowledge of the group as a whole.

Further professional stimulation is provided by the opportunity—in our own group, the obligation—of taking frequent clinical trips for attendance at medical meetings or for study in the large centers, and this without any compromise of the proper care of the absent member's patients or any loss of income to himself.

Concentration under the care of one individual of all the patients who fall into any particular field makes possible the development of the specialty fields even in a relatively small clinic. Group coverage of patient care allows to each doctor in normal times adequate time for leisure, study and research.

Lay Employes Play Vital Part

The accumulated volume of work produced by the group permits the economical employment of adequate nonprofessional but well-trained assistants in the administrative, secretarial and technical services that make such an essential contribution to the success of medical practice.

If, in addition to the organization of a staff as a functioning unit, that unit is developed around the hospital as the focal point, further advantages become apparent. Such is the situation in our own case, the office building of the Hitchcock Clinic being erected on the hospital grounds with direct access to the hospital building. Time and energy of the doctor are conserved by the elimination of possibly several trips daily between the hospital and an outside office.

The physical contiguity of the clinic and hospital permits further reduction in the duplication of facilities within the community, inasmuch as the hospital laboratories of clinical pathology, radiology and physical therapy serve the patients of the clinic. It is then logical for these departments to be administered as a cooperative enterprise of hospital and clinic, thereby achieving the economy of larger volume and avoiding the setting up of duplicating and competing facilities by the clinic.

Further duplication is avoided by providing a unit medical records sys-

tem, so that the entire medical record of any individual as in-patient, out-patient or home-patient is at hand whenever and wherever he is seen.

The hospital expansion, which has accompanied the staff development, has included many factors that have been important in extending medical care throughout the area. During these seventeen years the hospital's capacity has increased from 75 to 200; the number of towns in New Hampshire and Vermont from which patients originate has increased from 121 to 190.

Compared to an enrollment of 32 student nurses, there are now 110, with a similar change in nursing supervisors of from 5 to 20. Training schools for medical technologists and x-ray technicians are now operated by the departments of clinical pathology and radiology.

Improvement in the quality of the care rendered to the patient results directly from this coordination of personnel and facilities. The immediate availability of specialist skill and necessary technical equipment encourages consultation and special examination and, if such are necessary, saves the patient an immeasurable amount of time and energy in obtaining them. The ease of direct and personal discussion between the attending physician and any or all consultants permits the development of a unified opinion and definite and specific conclusions that can be transmitted directly and immediately to the patient.

Service Available at Low Cost

Patients in the hospital find the services of the physician—or any specialist service that may be necessary—immediately available in case of emergency. The economies referred to make it possible to render this service to the patient at the lowest cost consistent with the quality of the service.

Since our clinic exists in a relatively low fee area, our interest in economy is necessarily real. No outpatient department is maintained by the hospital, free cases being handled in the clinic along with the private patient. There are no standard fees and the fee, as established by the business office, is not computed on an arithmetical addition of procedures or numbers of consultations but is governed by the conception of the group effort as a unit service. It is based on the patient's ability to pay, with some consideration of the contingent expenses of the illness and the result to the patient. In those occasional cases where a relatively large fee is just and fitting, only a fixed portion can go into operating income. The balance is allocated to a sinking fund for the purchase of equipment or the development of projects that would not otherwise be possible.

Considerable economy to the patient results from direct access, when indicated, to the doctor in the special field. In the case of a telephone request for a home visit, for example, a trained receptionist is in a position to send a pediatrician or an otologist rather than an internist, thereby saving time and expense for all concerned.

The further development of group medicine will be a large factor in the distribution of well-trained men, who in recent years have been produced in infinitely greater numbers than in the past. At present, this type of man has been forced to stay within relatively large population centers in order to find the equipment and atmosphere suitable for reasonable use of his training.

The principle of group practice makes possible the establishment of more widely disseminated small centers of medical service that will increase availability of care to patients and, at the same time, provide those circumstances and facilities requisite to the professional satisfactions so necessary to contentment.

Certainly, it has been our experience that there is no scarcity of medical personnel seeking such a combination of circumstances. Important, too, are the immediate utilization of the training of such men and the avoidance of the usual wasteful period of waiting for the development of that type of practice for which they have been trained.

Lest it seem, however, that we would imply that group medicine is a panacea for all the ills of medical service, let us proceed to a discussion of its problems and complexities.

In the first instance, group practice requires a high degree of cooperation among the participating physicians, with subordination of personal ambitions — professional and sometimes financial—to the best interests of the group. Doctors, in general, are confirmed individualists, and personal attitudes are important in achieving and maintaining full harmony within the organization. In this respect, younger men may find it easier to work together than might older men.

Much thoughtful consideration must be given to the form of the group organization. No one type of structure will serve all situations and any given group must be developed according to the circumstances under which it arises and the needs it intends to serve. Certain groups have gradually grown up around one individual of forceful personality and outstanding professional achievement. This individual is then the dominant figure in the determination and control of its policies.

Other groups may come into being through the voluntary association of several men of approximate equality in age, professional training and ability, and under these circumstances the organization logically takes the form of a partnership on a basis of equal responsibility and equal sharing of control.

Basis for Remuneration

Another basic problem concerns the remuneration of the various members of the group. Should the discrepancies now existing between different fields of medical practice, for example, surgery and medicine, be perpetuated in the group organization, or should men of equal training and ability be entitled to equal rewards, regardless of the financial productivity of the particular field in which they work?

It is the conviction of our own group that, since the success of the individual and the success of the group are in such completely reciprocal relationship, equality in training and ability should carry with it equality of reward.

If it is contended that the greater financial return ordinarily accruing to the surgeon, for example, is only a just compensation for the greater physical and mental strain under which he works, it may be pointed out that group association can provide the more logical compensation of release from many of the routine tasks that he must otherwise perform.

If the group is centered in the hospital, we would emphasize the necessity for achieving thorough understanding and utmost cooperation between the professional staff of the

clinic and the administration of the hospital. It is essential that trustees and superintendent keep constantly before them the fundamental purpose of a hospital—to provide the physician with facilities for the most effective care of the sick.

It follows from this thesis that the professional staff should have the controlling voice in affairs pertaining directly to professional care and should have considerable weight in those related aspects that affect the welfare of the patient somewhat more indirectly.

This does not imply that full authority over certain aspects of the hospital management should not be delegated to the superintendent and there devolves upon the professional staff, of course, the obligation to understand and cooperate in these administrative problems. We are convinced that joint committees of the staff and trustees to which any major problems of hospital policy are referred form a valuable mechanism in achieving these aims.

From the patient's point of view, in the early years of our clinic the objection was frequently raised, with nostalgic reference to "the old family doctor," that group practice destroys the personal relationship between patient and physician. This is a definite danger that must be guarded against lest the operation of a group be so efficient and scientific that the patient is considered only as a diseased organism rather than a sick human being.

A correlative complaint is that group medicine interferes with the patient's time-honored freedom of choice in the selection of his doctor. Actually, under a group arrangement the patient is directed to the physician who is best able to deal with the particular malady from which the patient is suffering. In effect, then, the patient is assisted in making an intelligent choice for which he might otherwise have lacked the necessary knowledge.

To obviate these two criticisms, it has always been a fundamental rule of our clinic that the patient see first the doctor for whom he asks or to whom he is referred. In addition, every patient is the personal responsibility of some one member whose obligation it is to consider the patient as a whole and to assess and interpret all data gathered by the group and apply the total scientific analysis to the particular situation and personality of the patient.

One of the group of buildings that comprise the hospital and clinic.

If, however, some degree of the close personal relationship is lost the patient must weigh against this the higher quality of care received. The patient must be reconciled to transferring his confidence and loyalty from the individual doctor to the group. As time goes on, more and more patients come to the clinic for the general consideration of their condition rather than to any individual doctor in the group.

Another objection raised against the group clinic is that the very facility of consultations and special examination that the group affords leads to unnecessary utilization of these procedures and thereby to unnecessary expense to the patient. The only solution lies in the individual and collective ability and integrity of the members of the clinic. Here, again, the patient's confidence in the group is an essential factor.

If a group is to merit the confidence of its community, it must establish and maintain a high standard of medical practice. A closed staff affords an easy solution to this problem but is applicable only in certain special circumstances.

If we contend that a doctor can do his most effective work only in cooperation with other physicians, then it must be made possible for every doctor to associate himself, in some degree at least, with a group. This condition could be satisfied by the development of regional planning somewhat along the lines advocated by the recent reports of the Planning Commission of the British Medical Association and fostered in this country by such organizations as the Commonwealth Fund, Kellogg Foundation and the Bingham Associates.

Under such a plan, each region would have a central hospital fully equipped and fully staffed to give any type of medical care. Small hospitals throughout the district to which the surrounding physicians would have access would be adequately, though not as completely, equipped and would be covered for specialty service by the staff of the central hospital. The staff meetings of the small institutions would be attended by the consulting staff of the central hospital, thus making each practitioner one of the group of physicians in his region.

In our own area this arrangement obtains to a certain degree in the fields of pathology and radiology. The directors of these departments of Mary Hitchcock Memorial Hospital are consulting members of the staffs of several surrounding small hospitals, supervising the work of their respective departments and attending and participating in the staff meetings of these institutions.

Where Are They Now?

Never a dull moment in a Red Cross recreation hut

Dear Ellen:

First I beg to apologize for the carbon copy, but I have so little time for letter writing that I am sure you would rather have a copy than one of those informative little V-mail models!

I have been settled here at my final assignment for several weeks and feel now that I am part of the outfit. This is a beautiful spot from the standpoint of scenery. The hospital is situated among hundreds of coconut palms and at certain levels we have a lovely view of the harbor. The climate is, well, the hottest I have ever felt. I stay wringing wet most of the day—but everyone else feels the same way, so we all laugh about it and take it in our stride.

One Pail of Water for Three Baths

Just for example, we all planned big dates for New Year's Eve. I had three dances to attend and that very afternoon, the water was cut off—no showers, if you can imagine! Three of us were able to get a pail of water from another outfit and shared that for a sponge bath. Of course we didn't feel too refreshed but it was better than nothing! One gets used to surprises like this and if you can keep your sense of humor, you can survive in this climate.

We have very comfortable living quarters, a small screened house divided into a living room and bedroom. We have a desk, bookcase, chest of drawers and large clothes cabinet heated with an electric light bulb (this is the only way to keep our clothes from getting moldy).

We have regular wooden beds with two Navy mattresses, quite comfortable for sleeping. Our laundry problem is really something; we do have washers but no hot water, and it is very difficult to find a washer that is not in use and also one of the irons. You can only wear your clothes once because of the dirt and heat so there is really need to wash almost every day.

Our day begins at 5:30 a.m., with breakfast at 6. I do my letter writing, laundry, sewing, cleaning our hut and some secretarial work until 8 a.m. We then open the Red Cross recreation hut and the boys flock in. We keep this open from 8 until noon and from 2 until 5 p.m. No work at night as all the boys must be under their mosquito nets by 6 p.m.

Our Red Cross building is 20 by 50 feet. We have a small library, piano, ping-pong table, victrola and pool table, writing tables and easy chairs. At the far end of the building we have two small rooms: one for an office, the other for a supply closet where we keep toilet articles, cigarets and chewing gum. We give these articles to any of the patients who need them as a great many have lost all their personal belongings in combat or have left them behind.

They Just Want to Talk

The boys for the most part amuse themselves, but they do love to talk and I find that most of my day is spent just answering questions, talking about their home town or state and admiring pictures of their families. Not only the patients but also the detachment boys flock in and just gab. It is impossible to do any secretarial work while the building is open.

The wards must be visited each day and this job I really like, for the bedridden patients always want us either to write letters home for them, give them emergency supplies or just reassure them that the American gals are waiting for them back home and are not going to marry the 4-F's! Most of the boys have never seen Wacs, Waves or girl Marines—and they are anxious to know how they look in uniform and what they do.

We had a bang-up Christmas. We had crêpe paper and red bells to give each ward and the patients took great pride in decorating. They even helped us decorate our building. It did look pretty ornate, but it reminded them of the corner drug store back home so we let them decorate to their heart's content. On Christmas Eve a group of nurses, detachment boys and we three Red Cross workers sang carols through the wards. On Christmas morning we dressed our little bugler, 5 feet 5, in red pants, hat and boots and with a decorated jeep we delivered a Christmas package to each patient. For one week before Christmas we wrapped packages in order to have enough to go around.

Christmas Jam Session

Christmas afternoon we had our party, with entertainment—an 8 piece band and magician, refreshments, ice cream, coca colas, candy and cookies. The boys seemed to love it and the afternoon ended up with a "jam" session and our funny little Santa Claus, out of his costume, acted as master of ceremonies. It was a lot of work but well worth the effort to give the boys a little happiness over the holidays.

My social life has been terrific. There are very few gals on the island, so we are swamped with attention. We have curfew here at 10 p.m. except for midnight curfew on Wednesday and Saturday so we do get a little rest. You can readily see that I have little time for reading.

Wish you could all be with me; it is an experience I shall never forget.

Bambie

(B. A. Moorehouse)
Formerly, Assistant Superintendent
New York Eye and Ear Infirmary
25th Evacuation Hospital
APO 708, c/o Postmaster
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Objections Overruled

Mr. Brough cites the law and good logic to prove that the provision of medical services by hospitals is not illegal or unethical—it is just common sense

ROBERT N. BROUGH

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FOR about a decade minority groups of the medical profession have been arguing against the practice of medicine by hospitals. Only minor attention has been given to the matter by hospital administrators because of a belief that actual experience would prove that the medical profession has no real cause for complaint.

Recent developments, however, indicate that an attempt is being made to create an issue where harmony and cooperation have prevailed and should prevail. A recent bulletin of the American College of Radiology makes the following statements which may well be carefully examined and evaluated.

Radiologists' Objections

1. Inasmuch as the practice of medicine by a corporation is not lawful, a hospital cannot legally practice medicine directly or indirectly by means of an agent, even though such agent may be a duly licensed physician.

2. It is unethical and unprofessional for a physician to enter into an agreement with a hospital to render medical services at a fixed stipend or on a commission or percentage basis.

3. A controversy exists between the medical profession and organized hospitals over the inclusion of medical services as a part of hospital service in Blue Cross plans. The issue has been joined and significant developments are to be expected.

4. A militant determination by local radiological societies should counteract the efforts of some hospital groups to make radiology a part of hospital service.

5. Radiologists should take care to be independent contractors practicing medicine within the hospital rather than hospital employes providing medical service to be sold by the hospital.

The claim that hospitals are illegally practicing medicine is fundamental. True, the A.C.R. limits the charge to the state of Ohio, but the same reasoning appears here and there in other statements by radiologists, with the result that a considerable proportion of the medical profession has been led to believe that it is unlawful for hospitals to practice medicine. Their point of view is quite natural because of a well-established legal doctrine that a commercial corporation may not engage in the practice of such professions as law, medicine or dentistry.

There is an important exception to this rule, however, which has been specifically granted to hospitals. The entire subject has been reviewed by Emanuel and Lillian R. Hayt, members of the New York Bar, in their "Legal Guide for American Hospitals." From that statement the following digest is made:

Not only does the legal doctrine that commercial corporations may not engage in the practice of medicine hold good but likewise corporations conducted for profit *cannot contract for medical services. Medical services . . . sold through the medium of insurance is the unlawful practice of medicine when offered by a commercial corporation.*

Charitable Hospitals May Practice Medicine. *The hospital today is recognized as a place where special facilities and personnel are available to the physician, the surgeon or specialist to aid him in more accurately diagnosing the patient's illness. Hospital care without diagnostic facilities and treatment destroys the very essence of hospitalization. . . . While a hospital may not be licensed to practice medicine, it may actually engage in so much of such practice as is customary and necessary in the proper conduct of its business.*

In the Woodbury case (192 N. Y. 454) the New York State Court of Appeals said that "hospitals, dispensaries and similar corporate institutions" do not violate the law by practicing healing or advertising to practice medicine. The exemption of charitable hospitals from the prohibition that no one excepting a licensed physician may practice medicine permits them to render a special service to the sick, weak and infirm. This cannot be done merely by furnishing suitable rooms and food to the patient but must include the trained care of nurses and medical attention from qualified persons. Hospitals . . . endeavor to restore patients to health with as little delay as possible. With that aim in view they must have the professional services of physicians and nurses and that of trained technicians in laboratory work and diagnostic and therapeutic procedures.

Where the hospital administration fails to furnish these services when required . . . the courts invariably hold the institution liable in damages to a patient who suffers because of the hospital's failure to (so) provide. . . . A hospital, rather than practicing medicine per se, is a place where medicine is practiced by physicians.

Legal Opinions Differ

A layman should be careful when commenting upon legal matters, as they are undeniably tricky. Legal opinions are likely to be as divergent as the poles, as everyone knows. Only competent authorities are in a position to outline the law, which naturally differs in various states.

Hayt and Hayt's summary is encouraging from the standpoint of the superintendent of a charitable hospital, as it seems to make common sense and to correspond to the actual facts. Some persons versed in the

law may claim that it does not apply in many of our states but, if so, the opinion may be ventured that a great deal depends upon what is considered to be the practice of medicine. Much depends upon terminology and definition.

The point with which administrators and trustees are concerned is that they do not wish to do anything illegal and yet cannot well carry on the full extent of their time-honored and normal functions if the American College of Radiology is right in saying that, "a hospital cannot legally practice medicine directly or indirectly by means of an agent, even though such agent may be a duly licensed physician."

Once concede that charitable hospitals cannot practice medicine to any extent and their position becomes practically untenable, as the ordinary person sees it. If they do not practice medicine, why do they have interns, residents, radiologists, pathologists and anesthetists in their employ?

Why Physicians Are on Pay Roll

Certainly, the hospitals have not engaged them for window-dressing purposes nor have they incurred large expenses because of secondary or strange motives. These physicians are on the pay roll because (a) they are needed for the proper care of patients; (b) only competent physicians can furnish such care, and (c) such physicians should be properly compensated for their services.

Therefore, it would appear that the American Hospital Association was quite right in 1939 in affirming the principle that "the provision of medical services in hospitals is part of the responsibility of the hospital and is consistent with the rights, privileges and obligations of hospital staff physicians under their medical licensure."

A large part of the vexed discussion concerning the practice of medicine within a hospital centers around a charge of so-called unethical practices. The A.C.R. has officially resolved "that it is unethical and unprofessional," in accordance with the provision of Article 6 of the "Principles of Medical Ethics" of the American Medical Association, for a physician to enter into an agreement with a hospital to render medical services at a fixed stipend or on a commission or percentage basis.

This leads to the conclusion that *if the charge is correct,* the vast majority of our hospitals are knowingly or unknowingly encouraging unethical practices. It is quite common for them to enter into contracts with physicians to render medical services on a monetary basis, either at a fixed stipend or on some other terms found to be mutually satisfactory.

For instance, a large proportion of the interns now serving American hospitals are paid a stipend. These young doctors would undoubtedly be most surprised to learn that one of their first acts in the profession is unethical. Actually, it is *not unethical* because to be unethical in the true sense of the word an act must be contrary to a high standard or good morals, harmful in motive or intent, detrimental to the common good or injurious in some way and yet not so wrong as to be illegal.

It is hard to see why it is unethical for a member of the medical profession to enter into a contract with a hospital to examine or treat patients for a fixed stipend, or a fee, because physicians actually enter medical practice expecting to be paid for their services. The arrangements they make with hospitals usually represent a mutually satisfactory method of payment for services rendered.

There is nothing fundamentally unethical about such payments, provided they are fair, reasonable and satisfactory to both parties, and further provided they do not injure any other member of the medical profession. The charge of unethical practices in this connection before being worthy of credence should be rationalized and substantiated.

Much more could be said to justify payments to radiologists on a salary or fee basis. Members of the medical profession in many instances enter into salary or fee arrangements, honorably selling their services without any thought of criticism. In research, in medical schools and to some extent in industry such contracts are common. Most of the honored men of medicine have been paid in this way.

Article 6 of the "Principles of Medical Ethics" of the A.M.A. properly prohibits contract practice "to a group or class of individuals on the basis of a fee schedule or for a salary or a fixed rate per capita," but that principle does not apply to the point at issue because no group or class is involved. The services are open to the public as needed.

Furthermore, the article provides that "each contract should be considered on its own merits and in the light of surrounding conditions. . . . The decision as to its ethical or unethical nature must be based on the ultimate effect for good or evil on the people as a whole."

In contracts such as are under consideration "the ultimate effect on the people as a whole" is good and the contracts should be approved, as they long have been. Equitable compensation arrangements between physicians and medical schools, hospitals and similar organizations are time-honored.

Is Insurance Work Unethical?

It is difficult to understand why hospitals should now be singled out for criticism. Would anyone seriously argue that a physician must not practice medicine for an insurance company or that it is unethical for him to be paid by it in any way, shape or manner? Certainly not. Medical directors of insurance companies are still respected members of the profession.

By equally good logic radiologists of hospitals should likewise be exempt from criticism if they accept salary payments because such payments neither harm nor deceive anyone.

The typical hospital point of view concerning the practice of medicine within hospitals is greatly at variance with the published expressions of radiologists. Until the latter assumed a militant attitude, the subject remained somewhat in abeyance. Now a judicial attitude should be assumed by all concerned and the correctness of the various points made should be established. Either the hospitals or the radiologists are right.

From the standpoint of logic, common sense and the welfare of the public it is clear that hospitals should be permitted to practice medicine as they have for many decades. In fact, there is no general objection by the medical profession as a whole to the maintenance of the status quo. Present practices should be upheld.

Four of the contentions of the radiologists have been answered. The remaining one concerning medical services and Blue Cross plans will be analyzed in a second article next month.

Central Sterile Supply has come to stay at Hamot Hospital

DONALD M. ROSENBERGER
Director
Hamot Hospital, Erie, Pa.

BY JUNE 1942 the facilities of Hamot Hospital, Erie, Pa., were being taxed beyond reasonable and safe limits. The severest bottlenecks had developed in the operating room and the nursing service.

Because the operating rooms could not be expanded and because graduate nurses were leaving for the armed forces faster than accommodations could be provided for a proportionate number of additional student nurses, it became imperative to do something both to relieve the operating room and to free the floor nurses of certain of their duties so that they could give a greater proportion of their time to actual bedside nursing care. The creation of the central sterile supply proved to be a real help in meeting this situation.

After studying all available literature on the subject, a survey was made of central supply departments in 12 hospitals in five cities. The hospitals chosen for observation were both larger and smaller than our own hospital, so that the efficiency of larger scale operations might be compared with ingenious job-combinations in departments of smaller size with less personnel.

The supervisor selected for the position, Thelma Gingenbach, R.N., was then sent to Philadelphia to work in the central supply department of Jefferson Hospital for two weeks. One day trips were subsequently taken to other hospitals by the newly chosen supervisor, the director of nursing and the director of the hospital so that plans and ideas might be further developed before the actual work of setting up the new department was begun.

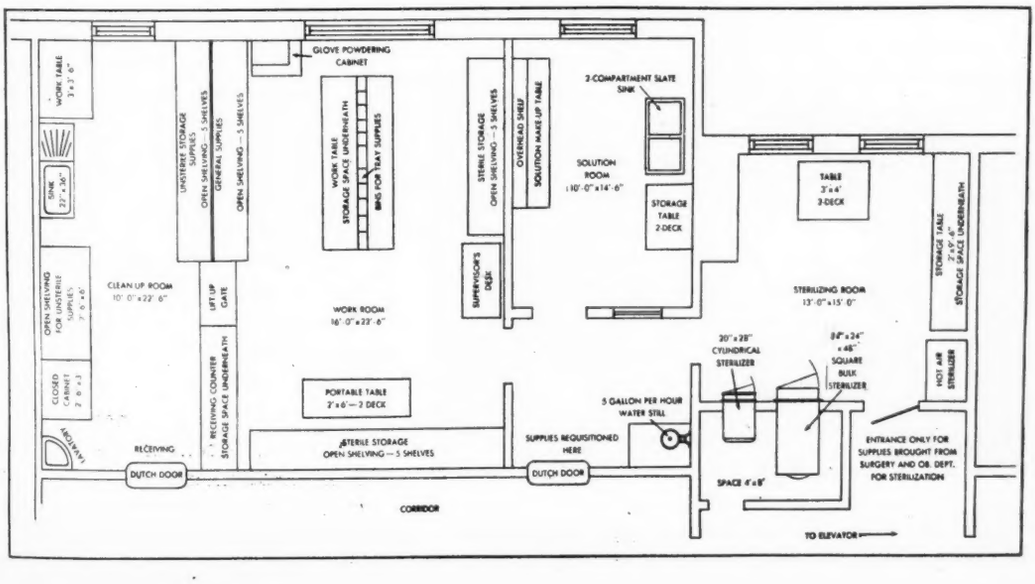
Four important but not altogether obvious conclusions resulted from our extensive studies. They are as follows:

1. The emphasis in a central supply department is properly on preparation of sterile equipment for professional treatments. It is this emphasis on preparation of sterile equipment that gives the central supply department reason for existence and it is the reason why our department has come to be known as the "central sterile supply." It is the sterilization service that sets the department apart from the traditional supply room that usually handles mops and office supplies, in addition to medical and surgical supplies.

By the same token, the central sterile supply is not to be confused with central sterilizing services that are rendered in conjunction with operating rooms and are under the direction of the operating room supervisor. The operation of a central sterile supply is a full-time responsibility involving a great deal more than sterilizing linens, gauze and rubber gloves as a sideline.

The supervisor cannot divide her time and responsibility and hope to meet the standards required of her by a central sterile supply department.

2. This department will be of maximum value only if emphasis on high standards of preparation is equaled by emphasis on the return of equipment to the department. A central sterile supply that does not



Layout of the central sterile supply room at Hamot Hospital. It will be noted that the receiving and dispensing doors are of the dutch type, with the bottom section bolted so that no unauthorized person can come in and help himself.

have the most exacting system for the return of equipment inevitably defeats two of the purposes for which it is organized: (1) assurance of adequate supplies available at all times and (2) increased economy of operation.

Hence, a "closed" system not unlike that used for travelers' checks has been developed whereby two persons must sign both the requisition and the check list for items dispensed and returned. The "closed" system also includes two slide bolts on both the receiving and dispensing dutch doors so that neither the inventory nor the sterile routine will be subject to disturbance.

3. A central sterile supply department is only as effective as its distribution system. It is preferable that the department be centrally located and easily accessible. However, some lack of accessibility will not offset the many advantages of the system. In large hospitals an electrically operated dumb-waiter and a pneumatic tube or a telautograph system doubtless would be highly desirable.

4. The central sterile supply is a workroom and not a show place. For this reason, and because it has been proved by bacteriological tests that sterile packages left on open shelves do not need to be sterilized any more frequently than do sterile packages kept in closed places, it was decided that open shelves should be used. Wood tables with composition tops were also selected instead of stainless steel tables. Thus, the establishment of the department was not delayed by any attempt to purchase critical materials for cabinets and tables and great sums of money were saved. The only sacrifice was that of beauty.

Miss Gingenbach (right) and a student set up trays at the work table.

After six months of operation of the central sterile supply, the following results have been observed:

1. Relieving the operating room of almost all of its former sterilizing work has vastly increased the efficiency of the operating room and has resulted in higher standards and greater economies and efficiency in the handling of linens, gauze, rubber gloves and other items formerly sterilized in the operating room.

2. Because floor nurses have been relieved of the time-consuming and responsible work of preparing treatment trays they have been able to give more hours to the bedside care of patients. It is estimated that 20 per cent of the floor nurses' time has thus been saved.

3. Uniformly high standards of preparation of treatment trays and other professional equipment have been achieved.

4. Centralizing the preparation of professional equipment has greatly facilitated readjustment of quotas for various types of trays and professional examination and treatment equipment, thus ensuring a smooth adjustment to changing demands. For example, as the use of plasma has grown by leaps and bounds within the last year, it has been possible to anticipate and keep ahead of increasing need for plasma sets.

5. Cash savings have accrued as a result of eliminating unnecessary duplication of stock in the various nursing departments, stricter control over medical and surgical supplies and quicker and better maintenance, repair and salvage of used articles

The dispensing window. Sterile packages are stored on open shelves. One of the tanks at the side of the shock cart contains pure oxygen, the other, a mixture of 70 per cent oxygen and 30 per cent carbon dioxide.

THE FINISHED PRODUCTS

FEMALE CATHETERIZATION TRAY (Center)

3 small solution basins
3 cotton balls in each of 2 basins
3 catheters, sizes 10, 12 and 14
1 large emesis basin
1 medicine glass
1 towel
1 pair gloves wrapped in gauze
1 specimen bottle with cap

INTRAVENOUS TRAY (Left)

1 Luer Kaufman syringe
1 saline drip
1 clamp
1 towel (incisional)
3 needles (18 g., 20 g., 22 g.)
Rubber tubing (3 feet)

HYPODERMOCLYSIS TRAY (Right)

1 Kelly bottle
1 glass funnel
2 glass needle adapters
2 clamps
1 glass graduate
4 needles—2 clysis 20 g., 22 g.
Y tubing
1 towel

and materials. It is estimated that savings thus effected may by the end of the first year of operation total as high as 25 per cent. As an important corollary it should be pointed out that savings can be measured in terms not only of dollars but also of critical war materials.

The department handles syringes, dressings, solutions and a number of miscellaneous items. Among the more interesting of the miscellaneous items are one shock cart and two burn carts. These carts, each of which is the approximate size of a bedside stand and equipped with 3 inch casters, contain all equipment needed for treating shock and for the Pickrell method of treating burns.

The carts are always "ready to roll" and can be dispatched to any part of the hospital at a moment's notice. A card showing the medical procedure agreed upon by the staff, together with a list of supplies and equipment, is on each cart.

While the primary emphasis of the central sterile supply department is on the preparation of sterile equipment, the system has been expanded to include the servicing of nonsterile professional equipment, such as oxygen tents and fracture carts. This type of equipment is as important in emergencies as is other professional equipment and therefore benefits by centralized control and supervision. One additional item handled by the department falls into a category of its own, that is communion sets for the last rites as administered by various churches.

Plans for future expansion of the service of the department include installation of a hot air sterilizer and the possibility of (a) processing and distributing sterile water for each floor and (b) manufacturing our own solutions. It is planned to use the hot air sterilizer, among other things, for the preparation of sterile hypodermic sets. Since such procedure is not currently being followed, it will be one more important addition to hospital service that can be credited to the almost unlimited possibilities of the central sterile supply department.

The department is staffed by seven persons, including two graduate nurses, one of whom is the supervisor. In addition to the two graduate nurses there is one student nurse on duty during each of the three eight hour periods of the day. One maid and one volunteer worker complete the personnel and are on duty eight hours per day. This staff has been found completely adequate to meet the needs of our 255 bed hospital.

The total inventory of the department consists of 66 items or units ready for immediate use. During October 1943 a total of 5788 items, or a daily average of 189, was dispensed promptly and efficiently with the assurance that the highest professional standards in preparation had been attained.

Scarcely a day goes by that doctors and nurses are not heard to comment favorably on the extent to which the department has improved the hospital service. The central sterile supply has earned a permanent place in our organization.

Take Charity Off the Pay Roll

An incentive plan for rewarding efficiency

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New York City

THE time has come for hospitals to cease to render charity on the basis of what they save on employes' pay roll. Strangely enough, this appears possible without increasing the over-all expenditure, if manpower is utilized efficiently and the number of employes is reduced proportionately.

Recently, industry and government have developed the incentive system for increasing production. The incentive system should not be confused with overtime or piece work. As the term implies, it means increasing the efficiency during the usual working period. Such a plan therefore assures the same basic cost or even less per unit of work produced, but the total earnings per individual are increased depending on the degree of efficiency or productivity.

Moreover, the work of each employe should be so correlated that the incentive spirit is spread throughout the organization, thus assuring management that each employe will see to it that his neighbor also performs efficiently.

To my knowledge the incentive plan has been adopted by hospitals only to a limited degree. I hope that the reason is not that we are unwilling to reward efficiency but, rather, that the difficulties in organizing the plan have temporarily postponed action. Where it has been used, experience has demonstrated that it is possible to reduce the total number of employes for, with the increased production by each individual, there is not enough work to be performed.

It therefore behooves all hospitals to adopt some modification of a plan that reduces the total number of employes so that the limited number available can be more adequately distributed and the individual's remuneration can be increased, thus attracting more efficient and loyal employes.

This paper deals with suggestions as to changes necessary for the adoption of an incentive plan. Our own experience at the New York Hospital has been limited to one department only, the laundry, but the excellent results obtained would indicate that more generalized use of the plan throughout the hospital would be beneficial. It should be remembered that in many phases of hospital work, production is not the true index so that other bases for computation of increased efficiency must be determined.

In general, it can be said that if the present output of each individual or group is considered as standard, then anything that is produced above that can be considered as increased efficiency and the employes should be so compensated. The adoption of a unit system generally fulfills the requirements, provided there is sufficient work to be performed over and above the present schedule.

It is possible to segregate certain types of work into a pool of work that can be performed when the routine duties have been accomplished. This will be discussed in detail when the various departments are analyzed.

Following is a brief discussion of the changes that might be instituted in the various departments in order to establish an incentive system.

LAUNDRY DEPARTMENT

In small hospitals the over-all production can be used as a basis. The present average production per day or per week should be obtained and the present hourly rate should be paid to each employe for production up to the established average. For each increment of increased production an increase in the hourly rate should be given. Based on industry's plan, 1 per cent increase in wages can be given for each 2 per cent increase in production. This over-all plan has the added advantage that all the employes in the department are coordinated in one productive unit.

In our own case, because of the large volume of work performed in the laundry, we have been able to classify the various types of work into groups. The incentive plan is now operating in the following units: classifying, washing and tumbling, flatwork ironing and fluff-dry folding. Similar plans are being worked out for marking, sorting, checking and wrapping.

Early experience with the incentive plan demonstrated that, owing to increased production and, to a lesser degree, increased volume, the amount of work available was insufficient for the production of our personnel, although prior to the adoption of the plan it had been more than it could do. Consequently, the individual employe was not able to increase his earnings. However, when the number of employes in those subdepartments was reduced, a happy solution was obtained: individual earnings were increased and the unit cost was decreased.

Moreover, since the basis for the plan was a group production, the employes stimulated one another and particularly the new employes who required a period of training. If any one of the group was inefficient, the other members brought it to the attention of the management inasmuch as one individual can reduce the efficiency and earnings of the whole group.

In the classifying unit the number of personnel has been reduced from six to five. Further improvement seems within reach.

A reduction from seven to six has been accomplished in the washing

and tumbling unit. The hourly bonus to this group is averaging 7 cents.

The flatwork ironing unit has shown the greatest improvement. The budgeted personnel has been reduced from 27 to 21 and for certain periods has run efficiently with only 18 employes. Production per operator has been increased from an average of 40 pounds per hour to an average of 66 pounds per hour. The average hourly bonus has been 8 cents.

The fluff-dry unit has been able to increase production sufficiently to obtain an average bonus of 3 cents an hour. The personnel was not reduced but additional items have been added to this unit.

HOUSEKEEPING SERVICE

In this department efficiency cannot be based entirely on production as measured by weight or number of items produced. However, with certain changes in our present practice, efficiency can be increased, provided supervision is maintained. A patients' floor or specified area is usually assigned to a maid or porter and the whole day is allotted for doing the work. There is no stimulus to do the work in less time.

However, if we consider the employe's present work as 100 units and permit him to obtain additional unit credits for additional work beyond his present assignment and within the present working hours, efficiency would increase with resulting increase in earnings and decrease in unit cost.

Many items can be pooled for just this purpose, such as cleaning screens, window shades, venetian blinds and windows, caring for casters and movable equipment, cleaning special areas not subject to time limitation, delivering and moving. If, therefore, the employe finishes the work on his ward or floor at 3 p.m. instead of 5 p.m. he could work on the "pooled" items and obtain additional unit credits, based on either hours of work or piece production.

If the regular working hours are now forty-eight per week, for each additional hour spent in "pooled work" he would receive approximately two units of additional credit. If he were able to obtain two units of extra credit for five days each week his total units would be 100 plus 10, or 110 units, or 10 per cent more pay than his present salary. If cleaning screens were placed on a production basis, so that he received, say, one unit for every five screens cleaned, his total earned units would depend on the number of hours of labor.

Naturally, the method used will depend on the type of work to be done but, wherever it is applicable, the production method should be used rather than the hourly rate. The unit system is suggested for simplification of pay-roll procedure and for maintaining the employe on his own scale of earnings so as not to conflict with salary scales adjusted for period of employment.

It is quite evident that efficiency would increase without increasing the total cost, inasmuch as no unnecessary work would be done and the number of employes now performing the special jobs would be reduced.

Rug cleaning, polishing of floors and wall washing, whether done by specialized employes or the "pooled" group, should be on a unit basis for area produced in order to obtain efficiency. If performed by a specialized group, 100 units should represent the present average production. It would seem advisable to have at least one specialized individual for each major type of "pooled" work.

All supervisory personnel should remain on a fixed salary basis to avoid relaxation of supervision.

FOOD SERVICE DEPARTMENT

The basis for incentive work in the nutrition department is somewhat more difficult because much of the work is of a service nature. Obviously, it would be rather difficult to pay the pot washer or the delivery boy according to the number of pots washed or the number of deliveries made because both items would be within the control of the employes themselves. However, the number of meals served offers an excellent index of the work involved throughout the department.

In a small department all employes can be grouped together without classification into types of work. After the average number of meals has been determined, 1 per cent increase in wages can be allotted for each 2 per cent increase in the number of meals served. Moreover, further compensation can be made for decrease in the number of employes, provided the work is distributed equally among them.

Let us assume that the average number of meals is 2000 a week and that 10 individuals each receiving $20 per week are employed. If the number of meals a week is 2000 or less they receive their basic pay of $20 per week. If the total meals were 2200, which represents a 10 per cent increase, then each employe would receive 5 per cent increase, or a $1 bonus.

However, if the number of employes were reduced to eight, the standard average of meals would be 1600 rather than 2000 because the original standard was 200 meals per employe. If the 2000 meals were served, or 400 more than 1600, the increase would be 25 per cent and the eight employes would each receive a bonus of 12½ per cent, or $2.50. In other words, the total cost would be $180 instead of $200 but each employe would receive $2.50 more a week.

In large hospitals the groups would be broken down into units, such as dishwashers, cooks, bus boys and cafeteria employes. This is necessary because the absence of one individual in a group would mean additional work to the other members of that group only and not to the entire force. The standard of meals for each group would vary depending on the type of work.

For instance, the cooks and pot washers in a main kitchen distributing food to patients, staff dining room and two cafeterias would have a standard based on the total meals served to these units, whereas the employes in the cafeteria would use the meals served in that unit only. The number and size of the groups would depend on the functioning of the department.

Tables could be devised for the individual units so as to facilitate computation of the bonus. If the service is provided in a pay cafeteria the income rather than the number of meals served could be used as the standard.

MAINTENANCE DEPARTMENT

The maintenance department presents further difficulties because in some of the subdepartments there is a lack of standard as to unit value. However, it is a field in which considerable time may be lost in going from one location to another and,

for that reason, incentive work would be most profitable.

Painting can be placed on a unit value of production. It is preferable to classify the various rooms and halls on a unit rather than on an area basis because of the variations in types of locations. A laboratory with exposed piping presents more work than an equivalent area in a hall. Painting ceilings requires more labor than painting walls.

The units can be determined from the present basis of production and should be considered collectively for the group involved. For example, a specific area is valued as 20 units. If this area is painted by one individual he receives 20 units in credit. If the area is covered by five painters, each receives four units of credit.

Whenever possible, it is preferable to have painters work in groups rather than individually. The same plan would be used for wall washing except the unit value would be lower than for painting.

Plumbing, carpentry and electrical work would require the establishment of a unit value for routine repairs. Repairing a refrigerator, a table or sink would be valued at a certain number of units. The value can be determined from experience since no injustice will be done to the employe if errors are made during the inception of the plan.

In these departments new work on construction might be done in addition to routine repairs. This can be placed on an incentive basis by accumulating the unit credits for repairs over an extended period of one or two months or even longer.

If during the period the individual accumulates credits for repairs equivalent to 100 units per week, the hours of new work based on 2.1 units per hour would be his bonus for efficiency. Naturally, management should make certain that there is fair distribution of routine work during the period. The number of hours devoted to routine work should be at least 60 per cent of the total hours for the period.

RECORD ROOM

The two general types of work performed in this department, *i.e.* circulation of records and stenographic work, can easily be placed on an incentive basis. The employes associated with the circulation of records may use the average circulation as a standard for computing the bonus feature. The stenographic work can be based on production of typewritten pages or, if the transcription method is used, on the number of cylinders transcribed.

NURSING DEPARTMENT

Nursing care, even that rendered by attendants and orderlies, is purely professional care and cannot be placed on any basis simulating production. Any such plan would inhibit the expression of the art of nursing and would undoubtedly be reflected in the patients' care.

MISCELLANEOUS

Many other individuals are employed in work for which there is no direct basis for production. These include store clerks, pharmacy assistants, accounting office personnel, clerks and clinic aides. It would be desirable for these groups to be integrated into an over-all plan.

However, the only available index is again the number of meals served, which, in general, is a good barometer of hospital activity. Although variation in production in these departments may not correspond directly with fluctuations in meals served, the changes either precede or follow the meal census.

It should be remembered that the increased production must be accomplished within the regular working hours and not by over-time work. Also, the practice in some hospitals of permitting employes to leave early if their work is completed does not offer the desired results. Although such a plan is, in essence, an incentive plan, it does not answer the problem of manpower shortage in that the number of employes is not reduced and it does not increase the individual's earnings.

These suggestions have been made with the realization that the plan may have to be modified to meet the individual hospital's needs. It is hoped that this presentation will at least stimulate experimentation in many hospitals so that an early and accurate evalution may be obtained.

Resourcefulness

IN THESE days of adversity, the administrator who is fortunate enough to possess resourceful department heads is singularly blessed. No matter how resourceful he is, his ingenuity will be of no avail unless his department heads follow suit. One of our elders used to remark that one can buy loyalty with the dollar. What he meant was that by granting increases in salary indiscriminately, his employes would stay loyal till the end (presumably the end of the bank account).

The resourceful department head, despite the trying period through which we are passing, will carefully weigh all requests for salary increases before submitting them to the administration.

The chief reason for requesting increases these days is the increased cost of living. Increased taxation is not a legitimate reason for such requests. Frequently, unless the increase in salary is granted, a hardship is inflicted on the worker if he is the head of a family. On the other hand, an employe living at the hospital will demand an increase, sometimes out of all proportion, simply because of the high cost of living. Our resourceful department head will point out to this individual that, while it is true that the cost of living has increased, in his particular case most of the increase has been borne by the institution. A little explanation with paper and pencil will perhaps convince our employe that, when he figures up the cost of his room, meals and laundry, he is not as poorly paid as he thought he was.

In the halcyon days, to which we all too frequently and mournfully refer as the "good old days," there were several applicants for one position. Now that the procedure is reversed, our resourceful department head will place his employes where they are most urgently needed and not spend a goodly portion of his day wringing his hands and wondering (usually out loud) what he will do next. The resourceful department head, the one who is conservative with money and knows how to organize his department efficiently in the face of a serious personnel shortage, is, too, at a premium.—JOHN F. CRANE, *assistant director, Montefiore Hospital, New York City.*

Prepayment Preferred for Obstetrical Service

JOHN RANSOM
Assistant Director
Johns Hopkins Hospital, Baltimore

SOONER or later, illness or injury necessitating hospital care falls to the lot of most individuals. For the well-to-do and for the indigent this presents a less difficult problem than for those who, out of modest incomes, try to maintain their self-respect by paying for what they get.

However, comparatively few members of this income group make provision in their budgets, if budgets they make, for medical and hospital expense. Consequently, when faced by the sudden necessity for the service of physician and hospital, many of them find themselves unable to meet the costs thereof out of either current income or savings. Hospitalization insurance is providing at least partial coverage of this risk for many persons in this income group.

The need for obstetrical service does not arise with such catastrophic suddenness as may illness or accidental injury. It is known some months before the more expensive part of such service is required. Nevertheless, many expectant parents make little or no provision to meet these costs. Essential household expenses, installment purchasing and lack of thrift and financial planning are frequent causative factors in many such situations.

Hospital Is Financial Godfather

Hospitals that provide obstetrical service have had to render that service free or have had to write off as uncollectible the accounts of many such patients whose improvidence rather than their indigence has made it impossible, or at least very difficult, for them to pay the hospital costs of the service they received. Hospitals have thus been the financial godparents of many babies born in their delivery rooms.

To protect themselves against such unnecessary loss of income and to assist such patients to meet these costs out of their current income, a considerable number of hospitals have developed and maintain plans of prepayment for obstetrical service.

Because I am familiar with the plan in use at Johns Hopkins Hospital, an outline of that plan is presented in considerable detail, with a discussion of variations from it in similar plans in operation in several other hospitals.

For the fiscal year 1935-36, the income of the Johns Hopkins Hospital for prenatal dispensary service and ward obstetrical care approximated $10,000. In the year beginning July 1, 1936, a prepayment plan was inaugurated. Prepayments under this plan have been as follows:

Year	*Amount of Prepayments*
1936-37	$10,899.39
1937-38	17,248.05
1938-39	14,999.79
1939-40	18,186.65
1940-41	22,752.61
1941-42	38,333.99
1942-43	45,302.43

In considering these figures one must note that they reflect the economic situation in Baltimore for the several different years covered, that Johns Hopkins has a large number of colored obstetrical patients who in normal times are all in low-income groups and the additional fact that it admits as free patients those who are unable to pay. These prepayments do not represent *all* the hospital income from ward obstetrical patients.

Some patients who had not paid all the costs charged them paid the balance or a part of it on discharge from the ward or later. Nor do the figures include income from private and semiprivate patients.

The principal features of the prepayment plan are as follows. At the time the patient is registered in the prenatal clinic, or as soon thereafter as possible, a registrar sets a rate for each such patient. This rate is based on the income of the patient's family, its expenses and other pertinent factors. Should it seem necessary, the patient is required to furnish data substantiating his statements as to income and expense. The patient, or in case of an unmarried minor her parent, signs an agreement to make the payments. Failure to keep up the payments may result in the cancellation of the patient's registration.

Rate Lowered If Necessary

Should it develop that there has been an unusual decrease in family income or increase in necessary family expenses before all payments have been made, the rate may be revised to a lower figure. The established fee covers not only prenatal clinic service, medicines and x-ray examinations but service in any other out-patient clinic as well, with the exception of such elective service as refraction and treatment for injuries sustained but not related to pregnancy. It is not dependent on the length of stay on the ward.

The fees charged for this complete service range from a maximum of $75 down to $5, with the one exception that a limited number of patients who can pay more than this maximum may be registered as "resident's cases." These patients are delivered by the obstetrical resident and pay an all-inclusive fee of $100.

In some instances not all of the scheduled prepayment installments are paid before the patient is admitted for delivery. In such instances the hospital attempts to collect the balance before the patient is discharged from the ward or, if this fails, to collect it still later.

For accounting purposes, $15 of the amount paid by each patient is credited to the out-patient department for prenatal clinic service. Should the patient pay only $15 or less in total, all that has been collected from her is credited to the out-patient department.

If for any reason a patient's registration is canceled or she is not ad-

Prepayment of Obstetric Fees

When Payments Completed	*Registrants*	*Total Fees*	*Per Cent of Fees*
Before Admission	603	$29,539.50	86.4
Before Discharge	192	2,374.00	6.9
After Discharge	87	2,280.50	6.7
Total	882	$34,194.00	100.0

mitted for delivery, a refund is made should the total amount she has paid exceed the regular charges for such out-patient service as she may have received.

The individual account of each of these patients is carried in the prenatal clinic only, the money collected there each day being turned over that day to the hospital cashier. The cashier carries on his books an account entitled "obstetrical deposits." This account he debits with the monies turned over to him by the prenatal clinic.

On the admission of a registered obstetrical patient the cashier is notified of the amount of the fee she has agreed to pay and the total of her prepayments. The latter sum he withdraws from "obstetrical deposits" and credits to the individual patient's account.

The prenatal clinic bookkeeper is informed of this withdrawal and credits her balance with that amount. In this way the "obstetrical deposits" of the cashier and the total of the deposits shown on the individual patient's ledger accounts in the prenatal clinic are always in balance and serve as controls, the one of the other.

With the adoption of the program of the federal government under which it pays for hospital obstetrical care of the wives of certain classes of men in the armed forces, the number of patients registered under the hospital's prepayment plan is reduced. Maryland has also adopted a program of payment for hospital obstetrical care for certain patients unable to meet these costs themselves. Such patients come not at all or only partially under the prepayment plan.

The Associated Hospital Service of Baltimore pays for hospital obstetrical service for its policyholders. Such patients are registered under the prepayment plan, the amount paid by the Blue Cross, which is on a per diem basis, being deducted from the prepayment rate set for the individual patient. Should the prepayments made by a patient, plus the amount paid by the Blue Cross, exceed the rate set for that patient, the amount overpaid is refunded to the patient.

Between Sept. 1, 1942, and Aug. 31, 1943, 950 patients were registered in the prenatal clinic, all of whom made prepayments toward the costs of the service they received. Of these 950 patients, 882 had paid in full by Nov. 30, 1943. Details are shown in the accompanying table.

The total fees of the 68 patients who, as of Nov. 30, 1943, had not paid in full amounted to $3719. Of this amount, $1462.25 was paid by patients before admission to the ward; $350.25 before discharge from the ward, and $283.50, after discharge. This leaves an unpaid balance of $1623.

Prepayment plans in other hospitals of which I inquired differ only in minor details. The rate for the service ranges from $40 to $75. In some hospitals there is no all-inclusive rate, the cost to the patient depending in part on the number of days she is on the ward. In case prepayments are made, they are planned to cover an average number of days, with refunds or further charges should the stay be shorter or longer.

Whatever variations in such a plan may seem expedient in a given hospital, a prepayment plan for obstetrical service seems to be good for both hospital and patient.

Child Patients Need Discipline

HOSPITAL life has a tendency to make children naughty and disobedient because they are spoiled by exaggerated love and unjustified pity on the part of nurses and doting mothers, aunts and grandmothers. The child's behavior becomes more and more egocentric. He and his sufferings become all important and the small tyrant recognizes that he dominates the environment.

Order, discipline and equality of treatment for all work wonders for the child's psychology. If there is no physical basis for crying, such as pain or suffering, no attention is paid to the disturbance. In time, the antisocial behavior ceases and even small children try to adapt themselves.

The strange environment, new impressions, fear of dressings and treatments and new faces among the nursing staff tend to make children fearful and shy. Even the physicians do not always deal capably with the child mentality.

Although the doctor cannot always make clear exactly what he is going to do, he must not deceive them. It is better to say before a blood test, for example, that there will be a finger-prick and a little pain rather than to say that the procedure "will not hurt at all." The child, quite fairly, feels that he has been deceived when it does hurt.

The patient's attention, meanwhile, may be diverted to aspects of the doctor's work—to the blood rising in the pipette or its gradual change in color. Certainly, the nurses should never portray the doctor as a menace or "bogey man" to the child. If they do, all future medical examinations and treatments will become difficult, if not impossible.

Treatment on an understanding basis and with sensible occupations to provide diversion and an outlet for his energies will strengthen the child in his will to recover. There are a greater cooperation with the staff and a quicker return to the normal mode of living.

The time spent in the hospital is by no means erased from the child's mind; it remains an experience engraved upon his memory. Therefore, this period should be utilized to create impressions that will be favorable for his own future life and useful to his family when he returns to it. In addition, his recovery itself is enhanced by sensible occupation and mental equilibrium.—ELSA NEUSTADT.

They All Come to the Coffee Shop

MRS. HAROLD H. TEARSE
Women's Board
St. Barnabas Hospital
Minneapolis

THE women's board of St. Barnabas Hospital, Minneapolis, opened the coffee shop on the seventieth anniversary of the opening of St. Barnabas, originally called the Cottage Hospital, founded by David E. Knickerbacker in 1871 as the first hospital in Minneapolis.

From its first day the coffee shop, with its lovely color scheme and decorations, has been an outstanding success. Its purpose was not to make money (although it is proving to be self-supporting) but rather to provide an attractive place in which families and friends of patients, as well as the physicians and nurses, could eat and relax in restful surroundings.

In the beginning we had a seating capacity for only 22 guests but we soon found that we would have to enlarge to accommodate 30, the largest number that could be served comfortably in the quarters that were available to us.

At the present time, we are employing a paid manager who works with a committee from our women's board. We have found this most successful since we serve about 1620 people a month and such a shop needs more constant supervision than we board members can give it with all the other claims on our time.

The coffee shop opens at 9 o'clock in the morning, serving breakfast to doctors and others, and remains open until 7 p.m. The women's board operates the coffee shop and the gift shop, which is adjacent to it, as the major project of the board. Its finances are kept separate from the hospital funds. Its profits are used for the support of special work in the hospital at the discretion of the board.

The hospital staff, as do the members of the board of trustees, feels that the shop has contributed a great deal to the comfort and friendly feeling in St. Barnabas Hospital.

How Small Is *Too Small?*

E. M. BLUESTONE, M.D. JOSEPH C. DOANE, M.D.
CLAUDE W. MUNGER, M.D.

"JUST what is the optimum bed capacity of a hospital so that it can operate most efficiently and economically? After a hospital reaches a size at which an assistant administrator and assistant department heads are required, the operating expense increases. There must be a certain size of hospital that can be operated more efficiently than it could be if it were from 25 to 50 per cent larger or from 25 to 50 per cent smaller."

This question, from a physician who is a member of a state hospital commission, is of interest to every individual hospital as it looks ahead to its future place in the community. It is equally of interest to the officers of state and national hospital associations and to public health leaders and city and regional planning experts who are now thinking about the development of hospitals, health centers and dispensaries for the post-war world.

Conclusions Are Similar

To present to our inquirer and to the readers of The MODERN HOSPITAL a well-rounded answer to this question, the subject was referred to three of the members of our editorial board who have had extensive experience as hospital administrators and consultants.

Although these three authorities have quite different backgrounds of hospital experience, it is interesting to note the strong similarity in their conclusions.

Dr. E. M. Bluestone, director of Montefiore Hospital for Chronic Diseases, New York City, answered as follows:

"From the point of view of the patient, a hospital that increases its size does so more or less at his individual expense. In his transfer from the comforts of his home and his family to the possible discomforts of the hospital and its group of strangers, he sacrifices something in order to gain something.

"It is important for us to determine the point at which he is best able to strike a good bargain. Having made the decision, the hospital should maintain, quantitatively, a sufficient number of beds and, qualitatively, a sufficient degree of specialization and division of labor to serve its patients best.

"No one can tell any given community the optimum size of its hospitals. Besides, there are general and special hospitals; there are teaching hospitals and research hospitals; there are taxpayers' hospitals and voluntary hospitals.

"It has been held for some time that we need one general bed for every 200 members of the population. In tuberculosis we used to speak of one bed for every tuberculosis death. (*This ratio has now been doubled by the experts.*—ED.) Half of the hospital beds of this country are given over to the care of mental disease.

"If a figure must be given, it is the consensus that a 500 bed general hospital is the size most likely to produce the best all-round results."

Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, agrees with this conclusion.

"When I planned the Philadelphia General Hospital, which is an institution of 2500 beds," he says, "I felt, and others called into consultation agreed, that in the administration of a large institution there is a maximum number of beds that can be administered efficiently as a unit.

"We decided that we would divide this institution into units of 250 beds each (see The MODERN HOSPITAL, March 1928, page 77). The men's and women's medical divisions constituted one medical unit of 500 beds. The surgical, gynecologic and obstetric wards were arranged in the same way. The neurologic wards consisted of a unit of 500 beds. These units were connected by cross corridors on each floor so as to shorten travel lanes.

"It was my plan to have a medical administrative officer in charge of each unit and a nurse in charge of each group of 250 beds, with a nursing supervisor over these two nurses. Requisitions, inspections and other administrative activities were to be routed toward the director of the hospital through these individuals.

"I am strongly of the opinion that 500 beds is the maximum number for efficient administration. In the construction of a larger hospital on the detached or semidetached plan, I believe that the layout of Philadelphia General Hospital is a good example of the appreciation and utilization of this principle."

Dr. Claude W. Munger, director, St. Luke's Hospital, New York City, states it well when he says: "I hesitate to hazard any definite opinion but I feel that the optimum capacity lies somewhere between 250 and 500 beds and that it is nearer the latter than the former.

Lose Hospital-Patient Relationships

"In general, there is a point, in bed capacity, beyond which it is inadvisable for an acute general hospital to go, if it wishes to continue to have a personalized service to patients insofar as the administration is concerned. If such a hospital becomes excessively large, it is only with increasing effort that it is able to maintain the service and the hospital-patient relationships that it would like to have.

"Opinions as to the optimum in bed capacity would differ. My experience has been in four general hospitals. The first had 40 beds, increased while I was there to 100 beds; the second, 175 beds; the third, 350 beds, increased during my incumbency to 1000 beds; the fourth and present one, 500 beds plus a country branch of 130 beds. I feel, accordingly, that I have somewhat run the gamut as to size of institution.

"Personalized attention was good

The answer to this problem will vary with the size of the community but the consensus is—not less than 250 beds and not more than 500

in the 40 bed, 100 bed and 175 bed institutions but, in my opinion, all three of those sizes were too small to enable one, without unusual effort and expense, to have an organization and departmentalization that were really adequate to all of the needs of the patients.

"It was much easier to approach this at 175 beds but even there we had to pay salaries to specialists, such as pathologists and roentgenologists, which were more than the average hospital of that size could have supported. We were able to do it only because of fortunate financial support in making up deficits.

No Specialist Problem Here

"The 350 bed institution did not offer these difficulties because there were enough patients to justify adequate salaries for necessary specialists and to permit sufficient departmentalizing without establishing departments that did not have enough to do.

"In my opinion, there was some loss of the personal touch in the 175 bed and the 350 bed capacities. However, it was not serious and was outweighed by the other advantages. It was easier to keep per capita costs more nearly within the reasonable range and 'efficiency and system' could be more readily attained.

"The 1000 bed hospital certainly lost out so far as personal touch with the administration was concerned. This was overcome, in part, by breaking the institution down into units, not only clinically but administratively. I am certain that as administrative head, however, I had more difficulty in getting my own ideas across and in making certain about the way the work was going than had been the case when the hospital had 350 beds.

"At present, here at St. Luke's, I find that it is still possible to know a great deal about individual patients, certainly those who present any unusual problems, and by extra effort it is still possible to personalize the service.

"I can visit our convalescent branch not oftener than once each week because it is 30 miles away and so I must delegate a great deal to the resident assistant in charge. However, we are able to correlate the work of the two institutions quite closely."

An illuminating discussion of this subject occurs in the "Hospital Survey for New York" (volume II, page 324).

"A hospital should not be so large that the director cannot have knowledge of and contact with the personnel. How large a unit one person can administer depends a great deal upon the personality of the individual man or woman in the position of authority, but it is questionable whether one person can run an institution of much more than 800 beds to the best interests of the patients therein and of the community that supports it.

"In the very large hospitals, especially those not of the vertical type of construction, transportation in itself presents a serious problem. It is a hardship to both patients and personnel if the distance between wards, operating rooms and other departments is great.

"However, this does not mean that urban hospitals should be small; on the contrary, the advantages of fairly large hospitals far outweigh their possible disadvantages. It is extravagant for the community to finance large numbers of small institutions, each with its own buildings, director and superintendent of nurses, and it is relatively more costly for small hospitals to provide high-grade service."

The survey also points out that the small hospitals in the area surveyed, in general, had lower necropsy rates, provided less physical therapy and had lower ratings on their physical plants with respect to buildings and grounds, fire protection and sanitation than did the hospitals of more than 200 beds. The smaller general hospitals also had lower percentages of occupancy at the time of the survey.

"The ideal hospital system for any large city is one or more 'unit hospitals,' depending on the size of the community served. Such a hospital is equipped to deal with any type of case any day. The clinical specialties should all be represented in it and the allotment of beds to each specialty should be large enough to justify the daily attendance of a member of the attending staff attached to such special service.

"What attracts a specialist to a general hospital is the existence in that institution of the full equipment and the trained personnel necessary for the hospital practice of his particular specialty. It is impossible for small general hospitals to provide these essentials for all the different medical specialties and, hence, they cannot hope to 'deal with any type of case any day.'"

The survey specifically recognizes that the smaller communities that are part of the New York metropolitan area may be justified in having small general hospital units, "but in New York City such institutions are uneconomical."

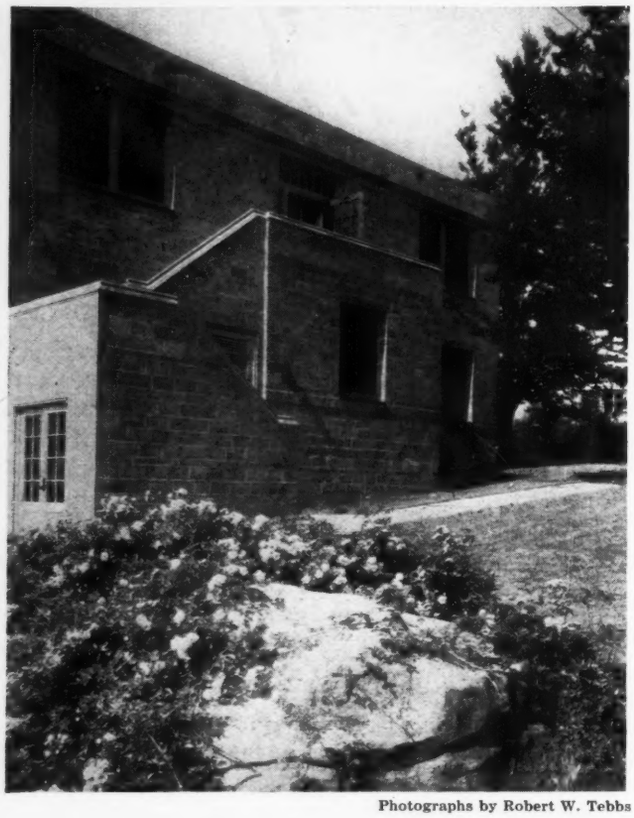
In view of these facts the survey recommended that no more general hospitals of less than 200 bed capacity be built in New York City or, except in unusual circumstances, in the metropolitan area outside New York City; that no funds be spent to reconstruct small hospitals not now used to advantage by the community, and that the number of relatively unoccupied [in 1934] general hospitals of smaller size be gradually decreased through merger with larger institutions.

Unit Hospitals May Be the Answer

Obviously, recommendations for a large metropolitan area would need to be modified considerably if applied to rural areas or smaller cities and towns. In such areas, the answer to the inadequacies of the small general hospital is probably to be found not in closing the small hospital but in supplementing its service by close affiliation with a "unit hospital," such as is being done with the assistance of the Bingham Associates in New England and the Kellogg Foundation in Michigan.

The Coast Guard Combines School and Hospital

ALFRED HOPKINS and ASSOCIATES
Architects-Engineers, New York City



Photographs by Robert W. Tebbs

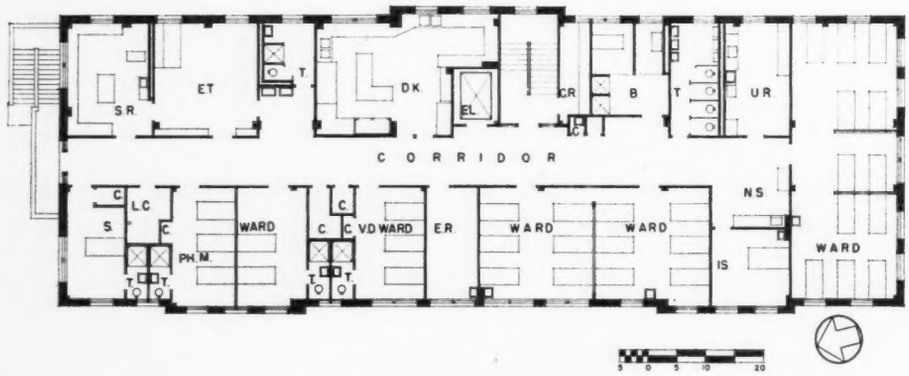
What is essentially a fire exit from the second floor becomes an interesting architectural feature as it steps down around the end of the building.

THE demands of war-time designing and construction are well illustrated in the small combined infirmary and training school for pharmacist's mates at the U. S. Coast Guard Training Station, Groton, Conn.

The building is designed as a hospital, a center for the routines of induction and periodic checkup, and out-patient or sick-call unit and a school.

On the first floor are the examination, out-patient and administration spaces and a classroom and study laboratory for students' use. The second floor is given over to wards, service rooms and minor surgery.

Considerations of sanitary finish and fire protection determined the use of masonry construction. A reenforced concrete frame with rough-textured concrete block walls manufactured and laid in such a way as to avoid monotony provides a dignified appearance that was economical and avoided the use of critical materials.

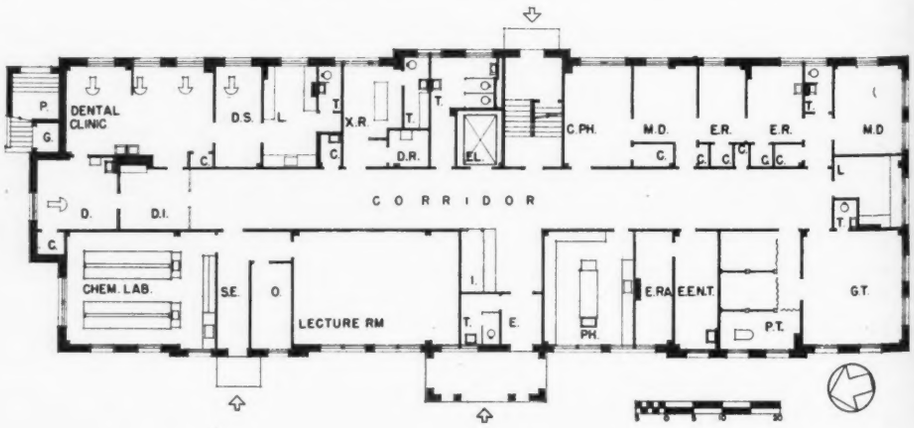


SECOND FLOOR PLAN

B.—Bathroom
C.—Cleaner's closet
C.R.—Clothes room
D.K.—Diet kitchen
EL.—Elevator
E.R.—Examination room
E.T.—Emergency treatment
IS.—Isolation room
N.S.—Nurses' station
PH.M.—Pharmacist's mates
S.—Single room
S.R.—Sterilizing room
T.—Toilet
U.R.—Utility room

FIRST FLOOR PLAN

C. PH.—Chief pharmacist
D.—Dental treatment
D.I.—Dental information
D.S.—Dental surgery
E.—Entrance vestibule
E.E.N.T.—Eye, ear, nose, throat
EL.—Elevator
E.R.—Examination room
E. RA.—Eye range
G.T.—General treatment
I.—Information
L.—Clinical laboratory
M.D.—Doctor's office
O.—Instructors' office
PH.—Pharmacy
P.T.—Physical therapy
S.E.—Students' entrance
T.—Toilet



R/A HARVEY F. JOHNSON
U.S.C.G.
Engineer-in-Chief

CAPT. R. R. TINKHAM
U.S.C.G.
Chief, Civil Engineering Division

CONSTRUCTION DETAILS

STRUCTURE: Concrete frame (piers, grade beams, columns, girders) with two-way arch floor system.

WALLS: Double, concrete block, waterproofed and thoroughly flashed, so that space between walls acts as uninterrupted condensation escape. Block is roughly textured on the outside, with color tone variations, varying heights of coursed ashlar and staggered joints giving variety. Interior finish, paint on smooth face block, except in the rooms that require scrubbing, where salt-glazed block was used.

ROOF: Flat, built-up tar and gravel over 1 inch rigid insulation on concrete deck.

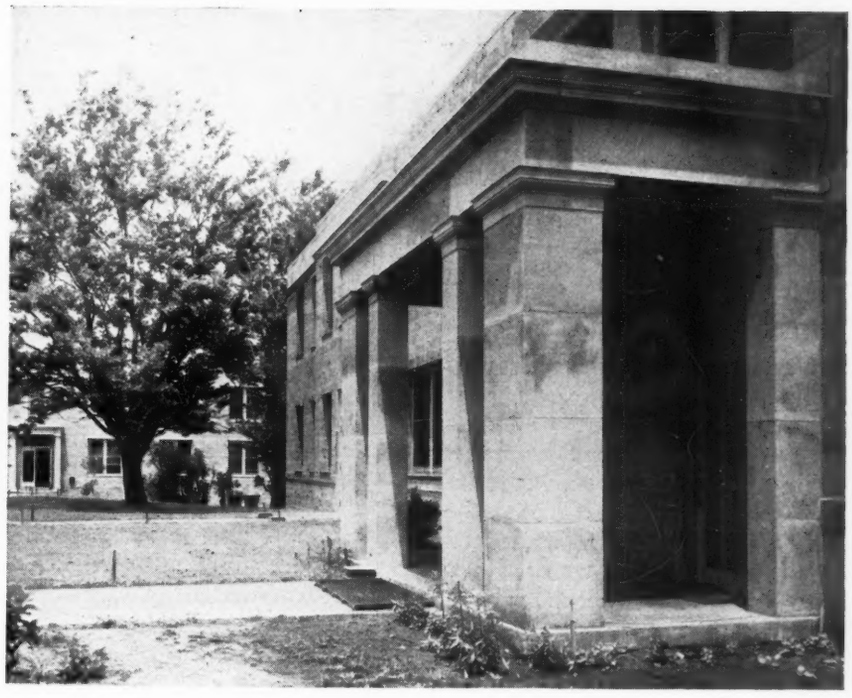
FLOORS: Linoleum except in the "wet" spaces, which are terrazzo.

ACOUSTIC TREATMENT: Acoustic tile units secured to underside of concrete slab.

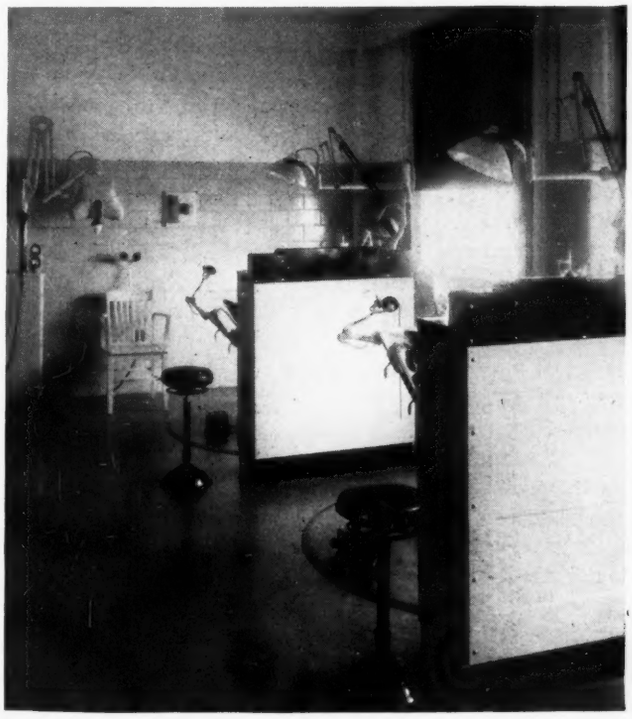
HEATING: Two-pipe steam system, with cast-iron radiators. Controlled by outdoor thermostat that measures steam supplied to the system in accordance with outdoor conditions. Steam for heating and hospital equipment, from central high-pressure plant of the station. Lightproof exhaust ventilation provided for x-ray darkroom.

ELECTRICAL: Supplied through unit type of substation in building with metal clad swtichgear and transformer. Complete nurses' call system. Fire alarm and public address systems connected to central administration unit.

COST: Excluding land, entire cost including fixed equipment, $174,000, or $0.67, per cubic foot. Cost per bed, $3900.



Above: The relationship of the building to others in the school group is apparent in the site planning, as well as in the scholastic dignity of such features as this entrance porch. Below, left: The dental clinic is located at the north end of the first floor. As in all spaces where sanitary considerations are important, it is finished with a high wainscot of salt-glazed block with concrete block above. Below, right: This 12 bed ward of the Rigs type occupies the south end of the second floor. Screened partitions dividing the ward into cubicles are built of war-time masonry and wood materials. Wall finish is painted smooth concrete block.



Nurses Need to Know

Principles of Oral Health

CLIFTON O. DUMMETT, D.D.S.

Assistant Professor of Periodontia and Oral Pathology
Dental Department, Meharry Medical College, Nashville, Tenn.

THE definite relationship that exists between conditions of oral and systemic health and disease is making for a widespread interest and alertness on the part of all those who are considered the "caretakers of human health." These would include the physician, the dentist, the nurse and the dental hygienist.

The average nurse has been getting the amount of basic science and medical training that would make for competence as the physician's aide, but it is questionable whether she has been exposed to enough instruction in those specific phases of oral health that would make for better service to her patients and to herself.

Perhaps the question of "service" might be clarified by the following illustration. Even in these enlightened days, there is still a certain amount of reticence in speaking openly about halitosis. The subject is still tabooed by society. Yet a casual inspection of daily newspapers and popular magazines shows us the large number of products that are advertised to prevent offensive breath.

Most of these advertisements depict a theme of the part offensive breath plays in breaking up romances and happy homes, the climax being reached when the advertised product saves the day for the offending party.

The importance of this is the indelible impression these stories make on numerous readers resulting, fortunately, in some cases in greater attention being paid to oral health. Unfortunately, other readers are often led to believe that as long as this product is used offensive breath worries are over.

The nurse should be informed about the simple facts of dental health and thus be in a position to advise patients correctly or refer them to the source of intelligent advice.

Illogical and unfair as it is, there does exist the feeling among so many so-called civilized people that although in males offensive breath may be ignored, depending on the circumstances, yet in women it is inexcusable. Daintiness, which is a desirable feminine attribute, is looked upon as a questionable masculine virtue. And in the final analysis a nurse is usually a woman so that she has this important "service" to herself in addition to rendering it to her patients.

What She Should Be Taught

Now comes the question as to exactly what should be told a nurse to make her aware of the importance oral health plays in the patient's welfare. A well-organized course in oral hygiene should be given to the sophomore or junior nursing classes. The following is a suggested one hour lecture course of eleven weeks. The lectures may be supplemented by demonstrations, motion pictures and charts wherever possible.

Introduction. An introductory lecture setting forth the functions and purposes of modern dentistry, medico-dental relationships and the aims of oral health. The most important point to be stressed is that the mouth is *not* a separate and distinct entity of the human body but is rather a connected part of the whole human system. In addition to this, oral symptoms are often indicators of systemic disease.

Oral hygiene. The scope of oral hygiene may be stressed at this time. Mention should be made of the ever-increasing tendency of all branches of dentistry to have as their goal the production and maintenance of oral hygiene. A simple but effective method of keeping a normal mouth healthy should be presented. This would include a short discussion of the toothbrush and the frequency and method of its use in cleaning the teeth; the supporting structures of the teeth (gingivae and gums) and the tongue, and the type and efficacy of various popular dentifrices.

Oral hygiene of the child. The acquisition of good habits should be started in childhood. This lecture should bring out some of the simple and essential points about the oral health of children, for example, the time for beginning the use of the toothbrush, the correct manner of usage, an accurate knowledge of the importance and eruption times of the primary and secondary teeth, the relationship between a normal diet and the soundness of the supporting structures of the teeth and the rôle of sugars in dental caries.

Halitosis. This subject should be of particular interest to the nurse for the reasons stated previously. Prinz has divided the etiological factors of halitosis as follows:

1. Causes arising from purely dental conditions. Ninety per cent of the cases of halitosis have their origin in purely dental conditions.
2. Causes arising from diseases of the soft structures of the oral cavity.
3. Causes arising from the nasopharyngeal region.
4. Causes arising from the digestive tract. It is interesting to note that, contrary to popular belief, the digestive tract is not as often the primary cause of unpleasant breath as most medical and dental textbooks have recorded.
5. Causes arising from bronchopulmonary diseases.
6. Causes arising from certain metabolic, infectious, febrile and genito-urinary diseases.
7. Causes arising from the presence of absorbed drugs and poisons.
8. Causes arising from foods, condiments and stimulants. Particularly significant here is recognition of the

dislike and distaste of many patients for breath odors of tobacco and alcohol.

Dental caries. This is one of the two commonest dental diseases and this lecture should serve to give the student some idea of what dental caries is, what causes it, what can be done about preventing its prevalence and the results of its extension to involve the dental pulp.

Dental abscesses. The definition and types of dental abscesses, their manner of formation, symptoms and treatment are all considered.

Oral sepsis. Previously it has been the custom of the medical profession to designate oral sepsis as Vincent's infection. It is true that the former predisposes an individual to the latter but it is fallacious to type them as one and the same condition. Some thought should be given to methods of treating and preventing oral sepsis as an aid to early recovery from both medical and dental diseases.

Vincent's infection. This is an important dental disease and a lecture should be devoted to its diagnosis, etiology, bacteriology, pathogenesis and treatment. It would be well to present the debatable question of its contagiousness. This previously accepted claim has not been substantiated by scientific fact.

Periodontoclasia. Commonly referred to as pyorrhea, this disease is the other of the two commonest dental diseases. A brief consideration should be given as to its etiology, diagnosis, pathology and treatment. Its relationship to some systemic conditions should be emphasized.

Oral manifestations of syphilis, tuberculosis and carcinoma. These manifestations are important from the standpoints of both self-protection and early recognition facilitating treatment. This lecture should be supplemented by clinical and photographic demonstrations.

Metallic stomatitis. The final lecture would include a discussion of oral and systemic poisoning as a result of bismuth, arsenical and mercurical injections in the treatment of lues and other diseases.

This outline is just a suggestion and may be modified or varied as the particular lecturer sees fit. The important point is to make the nurse conscious of the mouth as a part of the human body, as an indicator of local and systemic disease and as a social asset.

Salaries for Senior Cadets

The surgeon general explains the government's position on payments to seniors in the cadet nurse corps

THOMAS PARRAN, M.D.

Surgeon General, U. S. Public Health Service

At various A.C.S. war sessions and other recent hospital meetings, concern has been expressed over the proposed payment of $60 per month to senior cadet nurses who enter federal service. Many hospital administrators have planned to pay only $30 per month plus maintenance, the minimum specified in the law, assuming that no one would pay more than this. They now fear that federal competition will put them in a difficult position and also wonder whether sufficient consideration has been given to working with the hospitals on a voluntary basis to divert enough senior cadets to meet the needs of federal institutions and agencies. These facts were presented to Surgeon General Parran, who has answered them in the following statement.—ED.

THE amendment to the Bolton Act, passed by Congress and signed by the President on March 4, authorizes a uniform rate of pay for senior cadet nurses by the several federal agencies utilizing their services. This matter has been the subject of discussion in recent months by the federal agencies concerned and the Civil Service Commission. After careful consideration, it was decided "that the interested federal agencies will recommend to the President that he fix a rate of $60 a month." This statement was transmitted to the chairmen of the Senate Committee on Education and Labor on January 20 and of the House Committee on Interstate and Foreign Commerce on February 1 by the acting administrator of the Federal Security Agency.

In deciding that $60 per month was a reasonable rate of payment, consideration was given to the current rates of pay of women in the several women's uniformed services, as well as the salary schedules in the military and civilian branches of the federal government for graduate nurses. In this connection, also, it was recognized that the federal government traditionally has paid graduate nurses at a higher rate than has the average teaching hospital.

In our discussions here, we have been concerned that an undue number of senior cadets should not be withdrawn from any one training school per year. The U. S. Civil Service Commission and five federal nursing services have been most cooperative in this respect. The general policy will be not to accept for federal utilization more than 50 per cent of the senior cadets in any one institution.

The over-all needs of the federal services will amount to a relatively small percentage of the total number of senior cadets that will be available during the coming year. I think the proportion has been estimated at 20 per cent of the available senior cadets. The maximum needs of all of the federal services appear to be 2400 at any one time.

I agree that undue competition on a financial basis among the several agencies desiring the services of senior cadet nurses would be undesirable. It will be recalled, however, in the original Bolton Nurse Training Act, Section 2, that the intent is clearly that the needs of the federal hospitals for senior cadet nurses should receive preferential consideration if student nurses desire such service. Moreover, the same section of the act also provides that the student nurse will be paid a stipend "at a monthly rate of not less than $30 for the (senior cadet) period."

In our correspondence and contacts with individual nurse training schools, we find that institutions that increased considerably the number of admissions last year and this year are quite willing to release their senior cadet nurses, while the schools that have not done their part in increasing student enrollment are less willing to release their senior cadets.

In Case of Emergency Bedding

ALICE F. BREWER

Superintendent of Nurses
Gouverneur Hospital, New York City

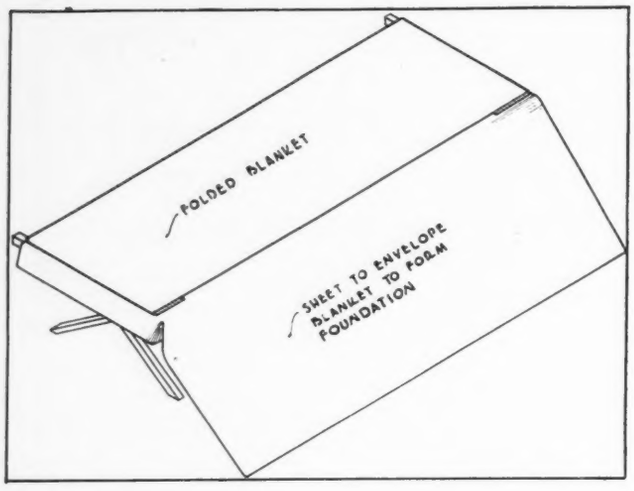
RECENTLY, Gouverneur Hospital, New York City, received a shipment of canvas folding cots to be set up for the reception of casualties from enemy action or other catastrophe. It was found that to open and set up a cot required several minutes and considerable muscular effort. Therefore, rather than lose time when an emergency arose, the cots were set up in a reception corridor and made ready for immediate use.

It was soon discovered, however, that traffic in the corridor, open windows and the proximity of the hospital to soft coal burning plants made it impracticable to make up the cots with the necessary bedding and linen because of the rapid accumulation of soot and dust.

Accordingly, at the suggestion of the medical superintendent, a bedding pack was devised that would enable us to make up cots without any loss of time as casualties were being received.

The pack includes the necessary linen so arranged and fan-folded that it forms a small compact bundle occupying little space. When needed it is placed in the center of the cot and is so easily unfolded that within less than a minute the cot is completely and properly equipped and made up with the required personal and bed linen for the reception of the patient.

The articles needed to make up the pack are: two blankets, two sheets, one spread, one pillow case, one pillow, one nightgown, one face towel and one wash cloth.



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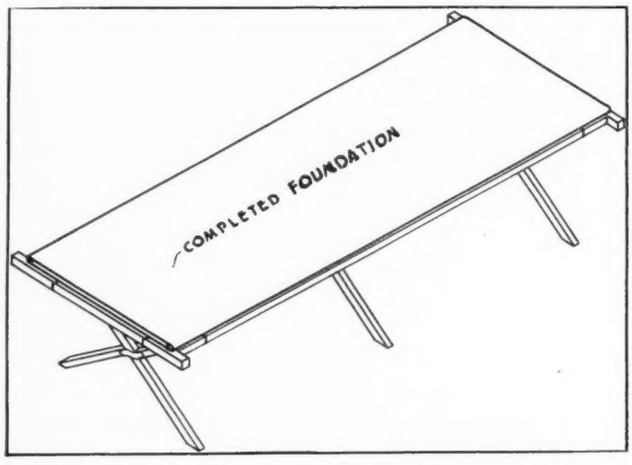
To make the foundation:

1. Place the sheet upon the cot so that the top and bottom ends extend equally beyond the head and foot of cot and one long end of the sheet is even with the lengthwise side of



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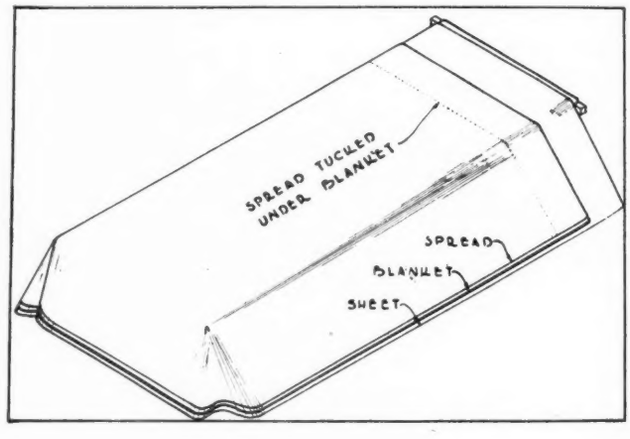

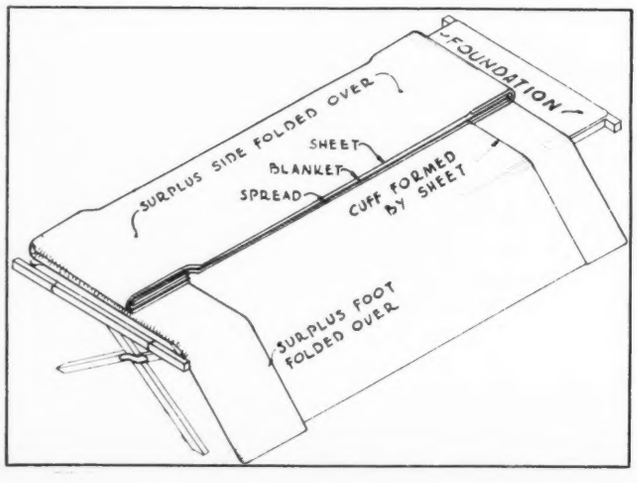

← 4

Catastrophe Is Ready to Unroll

the cot, the surplus width of the sheet extending down over the opposite end. **(Fig. 1.)**

2. Fold the blanket in its width to the width of the cot and place it on the sheet. Fold the surplus blanket length under itself at the head and the foot. **(Fig. 1.)**

3. Pick up the excess sheet hanging over the lengthwise edge of the cot and fold it over and under the blanket on the opposite side. **(Fig. 1.)**

4. Tuck in the head and foot of the sheet, enveloping the blanket completely. This forms the foundation. **(Fig. 2.)**

To complete the pack:

1. Place the second sheet even with the head of the cot with the smooth side of the hem down. **(Fig. 3.)**

2. Place the second blanket 6 inches from the head of the cot. **(Fig. 3.)**

3. Place the spread even with the head of the cot. **(Fig. 3.)**

4. Fold the upper edge of the spread under the blanket and bring the top of the sheet over it to form a cuff. **(Fig. 3.)**

5. Grasp the surplus bedding at the foot of the cot and turn it over itself with the folded edge even with the foot. **(Fig. 4.)**

6. Fold over itself the overlapping bedding on each side of the cot so that the folded edge is even with the side. **(Fig. 4.)**

7. Encase the pillow and place it at the head of the cot between the foundation and top bedding with the gown, towel and wash cloth underneath. **(Fig. 5.)**

8. Grasp the pillow and bedding at the head and fold once to the center. **(Fig. 6.)**

9. Grasp the bedding at the foot and fold to the center, leaving 6 inches between the opposing edges. **(Fig. 6.)**

10. Bring both folds together and tie crosswise. The complete pack should be about the size of a full pillow. **(Fig. 7.)**

To open the pack:

1. Place the pack in the middle of the cot so that it stands upright with the single fold on the canvas and the end containing the pillow toward the head.

2. Remove the tie.

3. Open the pack, roll the upper section to the head of the cot and the lower section to the foot of the cot.

To receive the patient:

1. Fan the upper bedding to the foot, place the patient on the cot, draw up the top bedding and bring it down over each side.

2. Drop the bedding at the foot of the cot and tuck under the surplus, mitering the corners.

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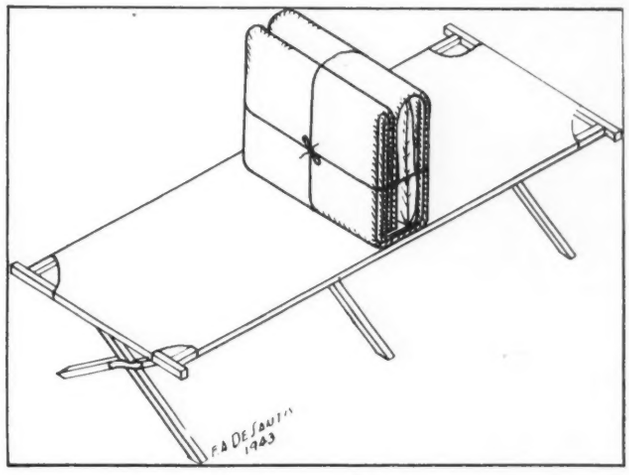

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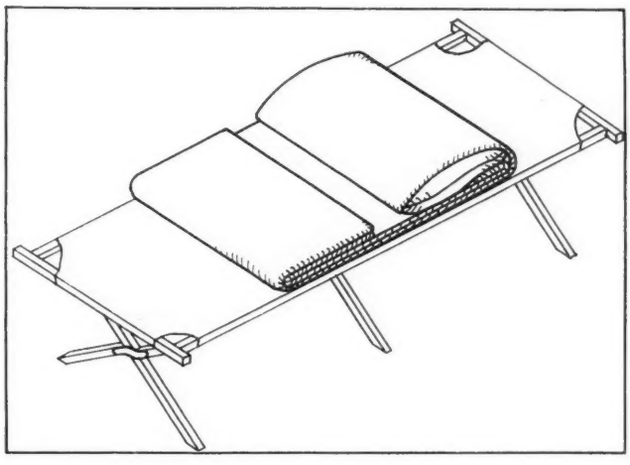

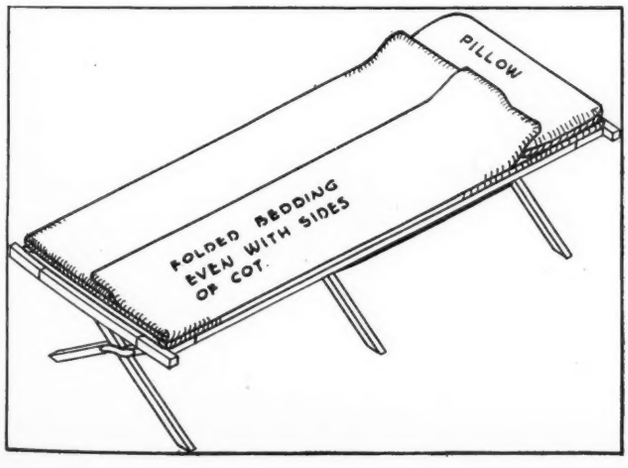

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About People

Administrators

Dr. Lewis E. Jarrett has been named head of Touro Infirmary, New Orleans, succeeding **Dr. A. J. Hockett.** Doctor Jarrett, a fellow of the American College of Hospital Administrators since 1935, has been director of the Hospital Division, Medical College of Virginia, Richmond, since 1933. He was president of the Virginia Hospital Association from 1935 to 1938 and prior to that was secretary of the association for two years. He is an active member of the American Hospital Association, having served on the board of trustees, in the house of delegates and on the Council of Hospital Service Plans and the Blue Cross Plan approval committee. He is a member of the editorial board of The MODERN HOSPITAL.

Dr. and Mrs. Lewis E. Jarrett

John E. Millizen, former business manager of the Chicago departments of the University of Illinois, has been named superintendent of the University of Illinois Research and Educational Hospitals, succeeding the late **Dr. Major H. Worthington.**

Lettie Jordan, assistant superintendent of Memorial Hospital, Huntsville, Tex., recently assumed the duties of administrator at City Memorial Hospital, Nacogdoches, Tex.

H. A. Cross has resigned as administrator of Good Samaritan Hospital, West Palm Beach, Fla., to head the Florida Blue Cross Plan that is now being formed. Headquarters of the plan will be at Jacksonville. Before becoming head of the Good Samaritan Hospital in 1943, Mr. Cross had been executive director of Jewish Hospital, Louisville, Ky. He was president of the Louisville Hospital Council in 1942 and was president-elect of the Kentucky State Hospital Association in 1943.

Josephine C. Lacy, R.N., has been selected as administrator of Lompoc Community Hospital, Lompoc, Calif. Miss Lacy was formerly associated with Monte Sano Hospital, Los Angeles, and Pottenger Sanatorium and Clinic for Diseases of the Chest, Monrovia, Calif.

Dr. David Wade, former head of Galveston State Psychopathic Hospital, Galveston, Tex., has accepted the position of administrator of Rusk State Hospital, Rusk, Tex.

Audra Isobel Ball, R.N., head nurse and senior chief nurse of the U. S. Indian Service from 1932 to March 1944, has assumed the duties of administrator of Berkeley County Hospital, Moncks Corner, S. C.

Dr. R. J. Marcotte, assistant director of New Haven Hospital, New Haven, Conn., since 1942, on April 15 became administrator of the House of Mercy Hospital, Pittsfield, Mass. Doctor Marcotte, who received his degree in medicine from the University of Michigan in 1932, is also a graduate of the University of Chicago course in hospital administration. He is a member of the Connecticut, New England and American hospital associations.

Mary B. Miller, R.N., resigned as administrator of Presbyterian Hospital, Pittsburgh, on April 1 because of ill health. Miss Miller has been an active member of the Hospital Association of Pennsylvania since its founding and served as its president in 1937-38. She has also been president of the Pittsburgh Hospital Conference, the Pittsburgh League of Nursing Education and the Sixth District Pennsylvania State Nurses' Association.

Lillian A. Hollohan has resigned as superintendent of Indiana Hospital, Indiana, Pa., the position she has held since 1929. Miss Hollohan was given leave of absence from the hospital last fall because of ill health but submitted her resignation when it was found that she had not improved sufficiently to resume her duties.

Mrs. Genevieve Nesby, formerly assistant to the administrator of Perth Amboy General Hospital, Perth Amboy, N. J., has been made assistant administrator of New England Deaconess Hospital, Boston.

C. E. Copeland was named superintendent of Missouri Baptist Hospital, St. Louis, at a meeting of the hospital's board of directors on March 21. Mr. Copeland joined the staff of the hospital in 1936, serving first as financial director and later as director of public relations.

James A. Behrendt on May 1 became assistant administrator of Evanston Hospital, Evanston, Ill., succeeding **James E. Moore.** Mr. Behrendt, who was an administrative intern at Presbyterian Hospital, Chicago, for a year, has been serving as assistant administrator at Evangelical Hospital, Chicago.

Ernest F. Schultz, superintendent of Christ Hospital, Jersey City, N. J., has resigned.

Dr. Ferdinand Haase assumed his duties as assistant director of Massachusetts General Hospital, Boston, on April 1.

Glenn R. Studebaker, for the last seven months director of Cumberland Memorial Hospital, Cumberland, Md., has resigned to join the staff of the hospital section, Government Division, of the War Production Board, under the supervision of **W. S. Brines.** Prior to his association with the Cumberland hospital, Mr. Studebaker was assistant director of Albany Hospital, Albany, N. Y. **John A. Lindner,** former director of Doctors' Hospital, Washington, D. C., has also been appointed to the hospital section of W.P.B.

Dorothy H. McMasters, R.N., has accepted a position as superintendent at West Central Minnesota Hospital, Graceville, Minn. Miss McMasters, who formerly served as superintendent of Barton Hospital, Watertown, S. D., and of William Newton Memorial Hospital, Winfield, Kan., recently received her master's degree in hospital administration at the University of Chicago.

Paul H. Fesler, whose resignation from Nopeming Sanatorium, Nopeming, Minn., was reported recently, has been

(Continued on Page 164)

Illinois Makes Progress

in providing hospital care for the medically indigent

RAYMOND M. HILLIARD
Director, Illinois Public Aid Commission

ILLINOIS has made notable progress during recent months in developing a plan for medical and hospital care for recipients of public aid and for the medically indigent that may be suggestive to other states faced with similar problems in coordinating a complex local administrative structure and overlapping statutory provisions for payment of these costs from public funds.

Also of interest are the methods used by the Illinois Public Aid Commission in a strongly "home rule"-minded state to work with and to interpret to responsible local welfare officials, hospital administrators and physicians the need for cooperative planning on a give-and-take basis in order to meet human needs more adequately in this important phase of public welfare and at the same time carry the full support of the taxpaying public behind the development of such a program.

Where Responsibility Lies

Responsibility for meeting medical and hospital costs for public aid recipients and the medically indigent, under present Illinois statutes, may be summarized briefly as follows:

1. Responsibility for recipients of general relief rests with the overseers of the poor in 1455 separate and autonomous local governmental units that are responsible for providing general relief to poor and indigent persons under the state's poor law. These consist of 1436 townships, the incorporated town of Cicero, 17 commission counties and the city of Chicago.

2. Responsibility for the medically indigent (or "nonpaupers" in Illinois terminology) rests with the same overseers of the poor in all but two of the 1455 general relief administrative units. The two exceptions are Chicago and Cicero. Cook County is responsible for the medically indigent in these two communities.

A workable state-wide plan for nonpaupers in Illinois was not possible prior to July 16, 1941, when Paragraph 25 of the poor law was amended to transfer responsibility from the counties to the general relief administrative units, with the two exceptions noted.

Because of the constitutional limitation on the power of the counties to tax, facilities offered the medically indigent prior to this date were meager or nonexistent. In the few areas in which there were county hospitals or county physicians, these were made available. There was no assurance whatever that care given by private physicians or voluntary hospitals would be paid for, unless the overseer of the poor paid the bill illegally or effort was made to collect from the county through a long and expensive lawsuit.

There remains a carry-over of this difficulty even at the present time in Chicago and Cicero where responsibility still rests with Cook County. Facilities offered by Cook County to the medically indigent residing in these two areas are limited to the Cook County Hospital and the services of the county physician.

Illinois considers as its medically indigent, or nonpaupers, provided for under this amended paragraph of the poor law (a) borderline private income cases that do not otherwise need public aid of any type, except when faced with medical or hospital needs, and (b) recipients of aid to dependent children, blind assistance or old age pension grants who are unable to pay for all needed medical and hospital care out of their grants or their private resources.

3. Partial responsibility for meeting medical and hospital costs for recipients of aid to dependent children, blind assistance and old age pensions rests on the state that administers these three programs directly through county departments of public assistance which act as local agents for the Illinois Public Aid Commission. The Illinois laws governing these three programs permit the inclusion of allowances for medical and hospital care in the monthly cash grants to beneficiaries but, for practical purposes, with the state appropriations gauged to expected federal matching, the amounts allowed are governed by the maximums established by the federal government ($40 for the aged and the blind; $18 and $12 for dependent children).

The only exception was a small special appropriation made in 1943 to meet entirely from state funds the cost of last illness of old age pension recipients. A further limitation is the policy of the federal Social Security Board of not matching assistance grants except those paid in cash direct to the recipient. Accordingly, allowances for medical and hospital care have been administratively limited to sums that remained within the federal maximums and all payments have been made to recipients who, in turn, are expected to make their own payment plans with physicians and hospitals.

Overseer Pays Last Illness Cost

Needs that cannot be met within a reasonable period through this means are assumed by the overseer of the poor, in accordance with his statutory responsibility for nonpaupers. Likewise, overseers of the poor take initial responsibility for paying last illness costs of old age pension recipients as part of their broader responsibility for all nonpauper care and are, in turn, reimbursed by the commission for such expenditures.

4. Responsibility for the over-all program, for contributing state funds toward costs and for supervising its administration, is placed in the Illinois Public Aid Commission, which

is responsible at the state level for all of the public aid programs. It supervises local administration and allocates state funds for general relief and care for nonpaupers to those local governmental units that require state fund supplementation to local funds levied for relief purposes and it administers directly, through county departments, the three social security programs that are financed entirely by state and federal funds.

With administrative responsibility at the local level divided in this complex fashion, the Illinois Public Aid Commission has developed in consultation with hospitals, physicians and overseers of the poor the following plan for coordinating the various local administrative units in meeting their respective responsibilities:

1. Rates of pay and details of policy and procedure governing the relationships among hospitals, physicians and the overseers of the poor in general relief and nonpauper cases are locally determined, subject to review by and general compliance with the broad rules and regulations of the commission. In some areas there still remain variations in rates and procedures as between units within a county but the trend is toward uniform agreements with all overseers within a county and sometimes even wider areas.

2. Rates of pay for physicians to be included in allowances for aid to dependent children, blind assistance and old age pension recipients were determined in consultation with a state medical advisory committee and have been uniform throughout the state.

Trend Is Toward Uniformity

As concrete plans for care of nonpaupers have developed, two tendencies have been revealed with respect to local reaction to these uniform rates for the three social security programs. In some areas overseers have agreed to adopt the state rates for general relief and nonpauper cases; in other areas, demand has arisen that the commission permit the uniform state rates to be modified locally to bring them into conformity with rates arrived at with the overseers for general relief and nonpauper cases.

Rates of pay for hospitals to be included in allowances for beneficiaries of the social security programs have not been established. In the absence of agreements with the state agency, home hospitals have arranged for pay at regular pay-patient rates, budgeting the pay plan over a long period of time; others have used a rate agreed upon with the overseers in the community.

The present trend is toward development of a common rate to be offered to all public aid recipients and nonpaupers, such rate to be negotiated by the individual hospital, the overseers and the commission.

3. To protect physicians, hospitals and public funds, the commission has developed a yardstick for distinguishing the medically indigent, or nonpaupers, from persons who are well able to pay for medical and hospital care at private pay rates. This yardstick is a liberal self-support budget, based on local living costs and related to but more generous than assistance standards used by the overseers to determine eligibility for general relief. It considers over a twelve months' period living expenses and debts, such as prior medical and hospital bills.

Ability to pay the medical or hospital bill causing referral or application for aid as a nonpauper is based on any surplus income after these other expenses and debts are allowed for. When there is no surplus the account is met in full by the overseer.

If the patient, or his family, is determined to be able to meet the bills in whole or in part from the surplus income, the physician and hospital are provided with financial information to enable them to make appropriate credit arrangements for the portion of the bill to be met by the patient.

4. To assure clear understanding as to which cases will or will not be accepted by overseers for payment, prior authorization from the overseer is required on all nonemergency nonpauper cases. In emergency nonpauper cases, care is, of course, instituted but the physician or hospital is required to give prompt written notice to the overseer. The overseer then determines the eligibility and notifies the physician or hospital whether the bill will be accepted in full or in part or will be rejected. If rejected or if accepted only in part, the overseer provides financial information to enable credit arrangements to be made.

5. The principle of free choice of physician and hospital is followed in all but a few communities for recipients of general relief. When contractual arrangements do exist for recipients of general relief, they are not carried over as a general rule to nonpauper cases. Recipients of aid to dependent children, blind assistance and old age pension grants are free to choose any physician or hospital they wish and to make their own arrangements for payment from the allowance for medical or hospital care included in their assistance grants.

Only Five County Hospitals

The facilities of the existing county hospitals (there are only five such hospitals registered by the A.M.A.) are rapidly being developed as supplements to rather than competitors with the voluntary hospitals in the area. This trend has grown out of the fact that the overseers are required to pay so much per patient day for each patient admitted from the local governmental unit to these county hospitals. These rates do not differ too radically from rates offered by voluntary hospitals in the area.

As a result, overseers have been working out with the voluntary hospitals a general plan defining the type of patient that will be sent to the county hospital and the type that will be sent to the voluntary hospital. Under present conditions, the county hospitals are coming more and more to be hospitals for the chronically ill and for persons who need convalescent care over a period before they can be returned to their homes.

In broad outline, Illinois' plan for medical and hospital care for recipients of public aid and for the medically indigent has its basic rooting in the state's poor law in which the greatest coverage is provided under existing statutes and in which the greatest flexibility is made possible through local administration accessible and closely responsive to local problems, standards and differences in cost.

On this base, the Illinois Public Aid Commission, representing the state's responsibility and interest in this field of public welfare, has sought to build an integrated system that would bring about on the part of the overseers full acceptance of their responsibilities and would take full advantage of state funds available for this purpose, especially the limited funds available for medical

and hospital care for beneficiaries of the three social security programs.

In the three years that the state has had to develop the program, progress made in coverage, community support and mutual satisfaction for all concerned may be attributed to the cooperative planning of the program at both the state and local levels; willingness on the part of physicians and hospitals to accept slow growth in the development of standards and rates and to cooperate in keeping the program restricted to the genuinely needy, and the policy of the state agency of leaving local details open for development at the local level.

Sixty Years of Service

ITS sixtieth anniversary is being celebrated this year by Memorial Hospital for the Treatment of Cancer and Allied Diseases in New York City. First known as the New York Cancer Hospital, Memorial Hospital was the pioneer special institution of its kind in the United States. When the cornerstone of the original structure was laid in 1884 there was not a single hospital in the country devoted exclusively to cancer.

Through six decades Memorial Hospital has fulfilled its purpose clinically and scientifically, having become an international center of cancer education. It represents the first instance in which all facilities for research, education, prevention and treatment of every phase of cancer are combined under one roof.

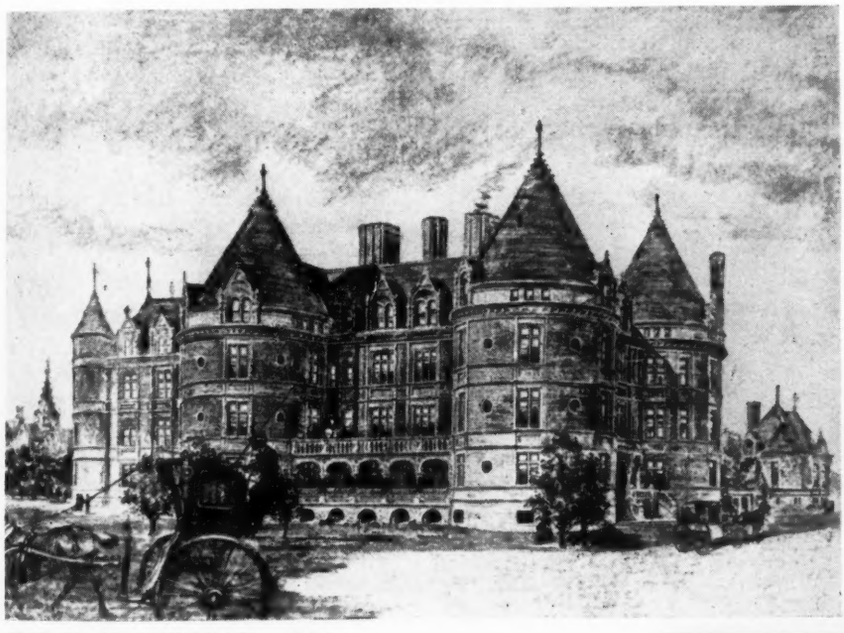
The hospital spanned the greater part of the professional life of Dr. James Ewing, one of the world's outstanding cancer authorities, who died in 1943. For thirty years, as president of the medical board and director, he contributed to the clinical advance of the institution and added greatly to its prestige.

With the occupancy of its new building in 1939 an era of noteworthy development began for Memorial Hospital. It is a 12 story modernistic building with a capacity of 250 beds. Distinctive among its many features is the only child's cancer ward in the world. Its x-ray therapy department includes 17 machines ranging in strength from 50,000 to 1,000,000 volts.

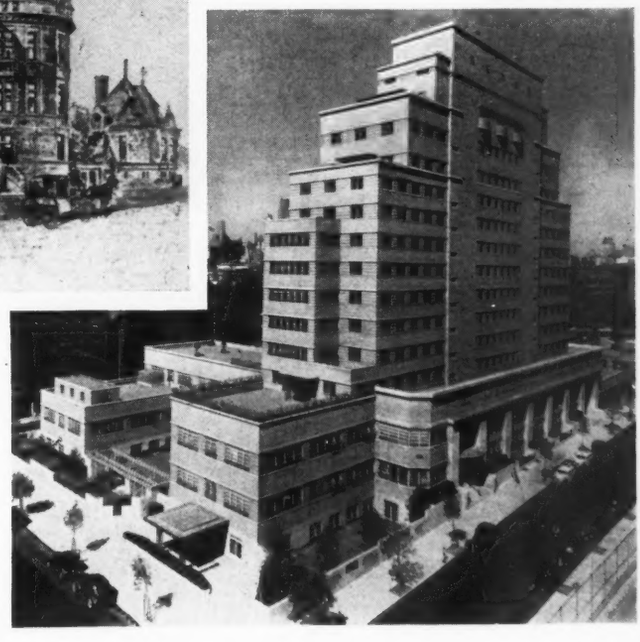
The radon emanation plant, designed and constructed by Memorial Hospital's physicists, is equipped with every possible device for the protection of the technicians handling the element. All research and diagnostic laboratories are assembled on the second floor so as to achieve the closest possible relationship with the clinical services located on the first floor.

An important development of the last five years is the prevention clinics, which occupy a suite separate from the rest of the hospital with a private entrance. The hospital auditorium seats 250 people.

Other features of Memorial Hospital are a museum of pathology and a scientific library.



THE FIRST BUILDING—1884



AS IT LOOKS TODAY—1944

Above: The hansom cab was in its heyday when the cornerstone of New York Cancer Hospital was laid. The pioneer institution has justified the vision of its founders and in 1939 entered upon a new phase of development with the occupancy of the handsome, modernistic 12 story building shown at the right.

Administrators Favor
Public Health Training

ALDEN B. MILLS and DEAN CONLEY

AN OVERWHELMING vote in favor of increased attention to public health training as preparation for hospital administration was recorded by the American College of Hospital Administrators in its poll of current issues on this subject.

Questionnaires were sent to 700 members and fellows of the college. A total of 184 replies was received and tabulated, constituting a 26 per cent reply. An analysis of the tabulated questionnaires follows:

1a. That public health training is considered of definite value in hospital administration was confirmed by the vote recorded on the questionnaire.

1b. The replies to this part of the question, as shown in table 1, are an interesting indication of trends that should be considered by the people who are now planning future educational opportunities for hospital administrators.

Communicable disease control, public health education and preventive medicine led the list, although they were not first in the suggested list of subjects in the inquiry. Hence, it is apparent that those answering the inquiry used discrimination in selecting topics for emphasis. Many checked several.

1c. Such a general question is difficult to answer and especially difficult to tabulate. Inasmuch as no specific list of instances or areas was presented, doubtless many people did not mention items that they nevertheless consider important.

As far as areas of work are concerned, nine persons said that such training was helpful in all areas and 24 specified the out-patient department.

Five persons thought such training would be helpful in the planning and construction of hospitals and five mentioned its value in setting up an employes' health service. Eleven mentioned the value in connection with the educational program for nurses and seven spoke of public health education work of the hospital as an important outlet for such interest.

Venereal disease control, with 21 votes, was the single specific subject that seemed to offer the most frequent opportunity of applying public health knowledge. Community and environmental sanitation had six votes. Various other types of patient care were mentioned 15 times.

As to the integration of public health technics into the hospital program, nine people stated that the hospital should serve as a community health center and two others evidently had much the same idea in mind when they recommended that hospitals provide headquarters and equipment for the health department.

One administrator recommended that the hospital might well be represented by membership on the board of health and another suggested the need of a local health and hospital council.

In the educational field, five members recommended that public health officers should participate in medical staff conferences and four others suggested that they give lectures to such conferences.

One reply stated more or less vaguely that hospitals should "promote" public health activities and three suggested making the personnel "public health conscious." Eighteen suggested cooperation with health agencies without being very specific.

1d. Informal methods of education, such as reading books, magazines and pamphlets, were considered important by 75 persons, and attending conventions, conferences and other meetings where public health matters are considered was recommended by 37 persons. Thirty-nine mentioned "contacts, associations, affiliations" and similar methods of keeping abreast of public health knowledge. Fifteen thought that actual practical experience in public health work was one desirable method while 16 suggested attendance at lectures. Other informal methods suggested less frequently included: movies, radio, use of library facilities, surveys and statistics, scholarships and writing for publication.

Short courses in public health subjects were suggested next most frequently, a total of 68 persons mentioning such things as institutes, refresher courses, special, short or "study" courses.

Reading courses were mentioned by 17 people.

Table 1—Aspects of Public Health Considered Most Valuable

Aspect	*Frequency Underscored*
Communicable Disease Control	112
Public Health Education	109
Preventive Medicine	94
Control of Tuberculosis	81
Infant and Maternal Morbidity	81
Venereal Disease Control	77
Poliomyelitis Control	55
Mental Disease	55
Environmental Sanitation	50
Cancer Control	51
Vital Statistics	47
Bacteriology	41
Personal Hygiene	41
Public Health Engineering	40
Industrial Hygiene	30

A.C.H.A. Poll of Current Opinion

	Yes	*No*	*No Answer*
1. A. Would training in public health be of value (or has it been of value) to you in your work as a hospital administrator?	168	12	4
B. If so, underline those aspects of public health most valuable, *e.g.* preventive medicine, personal hygiene, public health education, communicable disease control, vital statistics, industrial hygiene, public health engineering, environmental sanitation, bacteriology, control of tuberculosis, mental disease, venereal disease, infant and maternal morbidity, control of cancer, poliomyelitis.			
C. Please indicate specific instances or areas of work in which public health training is helpful in hospital administration and how public health technics can be integrated into the hospital program.			
D. How best can public health knowledge be made available to hospital administrators?			
2. Have you consulted your local or state health officer to determine if there are ways in which your hospital can cooperate more effectively with him? If so, please describe the results.	114	51	19
3. Has your local health officer or anyone from the health department lectured to the students in your school of nursing?	115	36	33
4. In view of the present emphasis on nutrition, do you believe that more hospitals should now establish food clinics to educate the public in proper nutrition? Remarks:	126	43	15

Conventional educational courses of one kind or another were suggested by 38 people, 24 of whom mentioned formal college or university courses. Extension study was mentioned by two persons. Four recommended postgraduate study and one undergraduate study. Seminars and nursing courses were also mentioned as sources of instruction in public health.

2. The more than two to one vote indicates that many administrators have actually taken steps to carry out their belief in the importance of public health. The results described by those who have attempted some cooperation with local or state health officers were so varied that it is difficult to summarize them briefly. A few quotations, however, will show that such consultation may be extremely productive.

"Excellent cooperation received. Local department of health survey undertaken."

"Prenatal blood examinations provided and venereal disease clinic established."

"Important cooperation on vital statistics and reporting of communicable diseases. Also, cooperation in inspection of hospital's milk and water and establishment of orthopedic and sight conservation work."

"Establishment of state-sponsored venereal disease, tuberculosis and crippled children's clinics."

"New program of licensing hospitals by state department of health."

"Student nurses now spend one month in city-county health unit."

"City health officer now attends the monthly staff meetings."

"Pneumonia control station and venereal disease program established."

"Local and state health officers help to teach our nurses."

"Public health department sends indigents at approximate cost to our hospital. We cooperate closely with public health nurses."

"We have close cooperation with the health department in tuberculosis and venereal disease control, maternity and infant care, dentistry, laboratory work, mental hygiene service."

"Cooperation in caring for polio cases."

"Health officers visit institution and offer suggestions."

"Supervision of milk from the time of milking to final consumption."

"Help us with infant mortality control and making hospital regulations effective."

"City and state appropriations hamstring every attempt to improve conditions."

"Cooperation is excellent; public health officers have definite appointments on consulting and attending staffs."

"Our local health officer is incompetent."

"Conducting and operating chest and venereal disease clinics."

"Cooperation satisfactory, especially regarding crowding in the maternity department."

"Facilities are available when the need arises."

"Our health officer only has contact with patients who have communicable diseases."

"The hospital provides space for monthly mental disease and diagnostic chest clinics and our student nurses assist at immunization clinics for school children."

"Public health department provides institute for graduate nurses on care of premature infants."

"Creation of a chair of public health at Washington University and a health center for St. Louis County."

"Little or no cooperation from health officer but splendid cooperation from local public health nurses."

Many others spoke of excellent cooperation resulting from their contacts with public health officers. The large number of methods of cooperation indicates that those administrators who say that there are no possibilities in this field have not used sufficient imagination.

3. Here again those replying had had favorable experience. Of those who answered "no," several specified that lectures in public health work were given to the students by persons other than public health officials and one reported that he thinks it a good idea.

4. Some of the comments on this question were enlightening:

"Higher wages and food rationing create need for nutritional program."

"This activity should not be limited to hospitals; they could help local health department."

"Such clinics are especially valuable among foreign elements."

"Too many groups are working on this project already."

"Shortage of dietitians prohibits this."

"We are conducting such a clinic and the results are gratifying."

"The misinformation given by radio and the press needs correction."

"Red Cross offers this service."

"Newspapers cover the subject well."

"Are especially valuable for low-income families."

"Government has created awareness of food values; hence this is a good time for hospitals to educate the public in how to obtain these values."

Many of those who voted against this idea said that they did so because of the difficulty in obtaining dietitians at the present time to carry on the regular work of the hospital.

The remaining four questions asked in the poll brought such extensive answers that it will be necessary to continue the presentation of results in a later issue.

It is not too soon to prepare for

Expanded Out-Patient Service

HOMER WICKENDEN

IN MANY voluntary hospitals, even in some teaching hospitals, the board of trustees and the administrator feel that if the "machinery" is well set up, with a good group of doctors in attendance and doing a teaching job, the out-patient department is functioning properly and can safely be left pretty much to itself.

However, if the out-patient department is to meet its responsibilities after the war and give its best service, under either evolutionary or revolutionary conditions, a strong policy-formulating group is going to be needed.

Some pretty clear thinking is going to be required concerning out-patient departments after the war. It is quite possible that in time, with the help of the medical profession, they may become the "tail that wags the dog."

The postwar era will see the return of many doctors, some of whom will be young men who have had short internships and no residency, some who have had no private practice and some who will need to rebuild their practice. They will all need hospital and clinical connections and it is one of the major responsibilities of our hospitals, particularly our teaching hospitals, to make opportunities for them.

On the other hand, many Army doctors will like the security of a government job and wish to continue in government medicine. The doctors whose medical education has been paid for by the government may be retained in the government service.

Many returning soldiers and their families will wish to continue their medical care at government expense and no doubt government hospitals will be made available to some or all of them. It is clear that there will be much more government medicine after the war.

This will be a challenge to the voluntary hospital and to private practice. It is not too early for leaders among hospital administrators and the medical profession to plan progressive steps in the evolution of new methods of providing medical care. Some extension of the present out-patient department setup is bound to develop. Provided sound economic arrangements are made, it can become an efficient means of dealing with large numbers of paying ambulatory patients on a co-operative practice basis by a group of doctors.

On the horizon one sees a "cloud not much larger than a man's hand" foreshadowing great development in industrial medicine. Will our out-patient departments be ready to provide the liaison with industry which that will require if industry is not to build up its own services?

If the government is to have a greater part in medical and hospital management, as seems likely regardless of whether the Wagner Bill is enacted, it will surely put pressure on the out-patient departments for greater service to more people. The economy of serving a large group in a well-equipped center with a co-ordinated staff of well-paid doctors will not escape either the people or the government authorities.

Who will work out the policies and the actual internal working arrangements for these broad developments in our clinics, particularly in teaching hospitals? Even though the Blue Cross could set up a pre-payment plan for such service, it

could be put into operation only if the internal arrangements are worked out by each hospital for itself.

It is suggested that while the final decision rests with the hospital's board of trustees in cooperation with the medical board, a special committee should be charged with making detailed studies and recommendations. There must be continuing studies because this evolution cannot be worked out all at one time.

Such a committee should represent various interests in the out-patient service if it is to do a good job. It is suggested that it be made up as follows:

1. A member of the board of trustees who is alive to modern trends in medical economics. He should be on the committee because of the capital investment which the out-patient department represents or will represent in its future development; because of the large budget that will be required, and because of the substantial deficit at which most out-patient departments now operate.
2. The dean, or his deputy, of the medical college associated with the department because of the use of the out-patient department for teaching medical students, interns, residents and postgraduate students.
3. Professors of medicine, surgery and obstetrics and gynecology, or any other major department, because of their supervision of the professional services and instruction in the out-patient department and because of their concern with obtaining sufficient clinical material for their staff and students.
4. The medical director of the hospital because of his responsibility for the patients transferred from the out-patient department to the in-patient service and because of his relation to the members of the house staff who work in the out-patient department.
5. The director of nursing service or the school of nursing because of the assignment of nursing personnel to the clinics and because of the importance of the out-patient department in the training of the nurse.
6. The hospital administrator—ex officio.

If this committee is to lead the way in making the out-patient department render its greatest service to the public and the medical profession, it must give a great deal of thought to the problem of adapting the available facilities to changing conditions and outlook. To be prepared to formulate its judgment it should concern itself with such problems as the following:

1. The determination of the amount of clinical material required by the various services for teaching purposes. This would guide the intake policies of the out-patient department. It might result in the establishment of minimum quotas for each service.
2. The periodic review of the budget of the department in the light of changing conditions in (a) professional and personnel requirements, (b) clinical requirements, (c) admission and in-take policies and (d) community needs and resources, such as the development of new city health center services.
3. The preparation of plans for the out-patient department to be reflected in the budget for each new fiscal year.
4. The adaptation of plant and facilities to the needs of the service. This might involve frequent studies of the use of floor space and the allocation of equipment.
5. The time given to out-patient service by physicians and methods of remunerating them.
6. The staff esprit de corps, including cooperation among departments, attendance, punctuality and discipline.

Internal statistical, financial and time studies should be made under the director of the out-patient department as a basis for working out policies. The preparation of such studies and other material for regular monthly meetings of such a committee would serve to keep the director abreast of what is really going on in his department. It should result in goals being set for him and the entire staff. It should reflect itself in greater efficiency.

For the period of the war the attendance in the out-patient department may drop off to such a point that sufficient clinical material may not be available for certain teaching departments. If, for instance, the number of patients attending the surgery clinic drops off, it might be advisable for the out-patient committee to set a quota of surgical cases in various categories to meet the teaching needs.

The director of the out-patient department then might be requested to work out a plan with smaller hospitals in the community which may not be equipped for highly specialized surgical cases that come to their clinics. This would promote the use of the teaching hospital as a center for small hospitals in suburban districts or any independently organized clinics.

Special study should be given to the possibility of using the teaching hospital's out-patient departments for large groups, such as labor unions or employes of certain large industries. The development of total medical service for employes in the Henry J. Kaiser industries and the interest of other large industries in the establishment of clinics and medical plans of their own should stimulate voluntary hospitals to work out arrangements under which industries call on them for service rather than set up their own separate services. Blue Cross plans and medical service plans may well cooperate in developing such arrangements.

Many hospitals already have arrangements with unions for service to bed patients. Why should this service not be extended to the out-patient department, with some arrangement for paying the physician in the clinic for his work, if necessary on a pooled-earnings basis?

Whatever unforeseen changes take place in the next decade, a strong central out-patient department committee is needed. Sound progress in the coming evolutionary process can only be made on the basis of continuing factual studies combined with vision and imagination.

Tell Employers the Truth

Refusal to tell an inquiring employer the truth about a discharged employe is a form of dishonesty that should not be tolerated anywhere, particularly in a hospital.

In many cases this refusal is like turning a typhoid carrier loose in the community without warning. If you believe that a discharged employe will not commit the same offense again and should, therefore, be given another chance, you should take the risk yourself and keep him in your employ unless you are prepared to tell the true facts to his prospective employer.

In no case should you indulge in half truths and mislead a new employer by failure to disclose the facts.—Henry L. Moses, *president, Montefiore Hospital, New York City.*

Reading Recommended

SAMUEL W. HICKS
Librarian
Albany Hospital, Albany, N. Y.

ANY hospital activity that is not included on the list of minimum essentials must justify its usefulness before the administration can seriously consider its permanent establishment. The patients' library movement comes under this classification.

Prior to World War I there were only a few outstanding examples of real hospital library service in which a librarian was employed. During the war, through the activity of the American Library Association, libraries were established and looked after by this organization in the various hospitals in which wounded soldiers were cared for. Physicians and nurses had an excellent opportunity to observe and study the relation of reading material to the progress of convalescence.

It was with this thought in mind that our patients' library at Albany Hospital, Albany, N. Y., was put on a permanent basis in 1935.

The library was established about 1930 by the local branch of the Junior League. All the work at this time was on a volunteer basis. Many hospitals relying exclusively on volunteer service encounter such problems as irregularity of service, loss of books and comparatively little attention paid to the selection of reading in its relation to the type and condition of the patient served.

After careful study of the service from the point of view of doctors, nurses and patients it was decided to put the library on a permanent basis. In order to show how this hospital library idea is implemented at Albany Hospital, a detailed description of some of my everyday experiences may be of interest.

On my rounds a few mornings ago I was greeted in this manner: "Where have you been for the past few days? I missed you." There was nothing personal in this greeting; it had to do with a slight lapse in the regularity of the library service owing to a cold I had picked up.

I often hear comments like this: "I have been trying to get this book from a rental library for some time and here I am in the hospital and I find you have it." My usual reply is, "There are latent advantages to be derived from a hospital stay."

These two experiences emphasize to my mind two of the most important essentials of hospital library work, namely, regularity of service and a relatively wide range of reading material.

How are these ends achieved? Albany Hospital has given the library the use of a large room adjoining the solarium on the eighth floor, easily accessible to both ambulatory and wheel-chair patients. The library is equipped with the requisite amount of shelving, reading tables and chairs. In addition, there are leather easy chairs and a leather divan.

In addition to the direct use of the library by patients, the librarian makes daily rounds taking books to patients and has found what may be called the follow-up system of call most effective. This is carried out by stopping the following day to see what the patient's reaction is to the book selected. The individual is a book patient under the librarian's supervision and should be attended with the same care as a medical or surgical case.

How are we able to provide a fairly divergent range of reading matter that will meet the demands of a hospital with a wide distribution of patients? We have four sources:

1. A yearly appropriation from the Albany Junior League whose interest in the library is a lively one.
2. Gifts of money from interested friends and former patients.
3. Direct gifts of books.
4. Use of the state library for special nonfiction requests. The state library gives the hospital full library privileges, holding the hospital librarian responsible for books borrowed.

The hospital librarian should constantly bear in mind the connotation of a relatively new word, bibliography. A book can be said to possess some therapeutic value if it can so absorb the patient's attention that the tendency toward introspection is greatly lessened.

The following method of selecting the right book for each patient has proved to be practical.

Outline to the patient the general classes of literature, *i.e.* biography, history, science, poetry and fiction. The last named classification can be further separated into historical novels, mysteries and romances (love stories to most). From his reply the patient indicates what are his broad reading interests. By passing from the general to the specific the book best suited to the patient's needs is selected. Educational background and emotional reaction should always be taken into consideration.

The success of this method is shown by the two letters appended which give the patient's point of view of the library service.

"Dear Mr. Hicks:

I thoroughly enjoyed your visits to my room and wish to take this opportunity of thanking you for the tact and thoughtfulness that marked these visits.

I am quite convinced that anyone remaining for any length of time finds it far easier to use the magnifying glass on his own ills than to use the telescope to look somewhat further afield on scenes of superior beauty.

Your tactful leading of the minds of those in the hospital out into diverting channels and among interesting ideas through your books has, I feel, a therapeutic value and should be considered a helpful part in the 'cure'.

May I say it was a pleasure to have our visits each day and may your valuable work prosper and bring you the reward of satisfaction among others."

• •

"Dear Mr. Hicks:

Many thanks for your nice service while I was at the Albany Hospital. You certainly made my stay there much more pleasant and your service is a great asset to the hospital. You have a fine selection of books and use great judgment in making the proper suggestions of reading matter to the individual. Again I thank you."

Where Do We Go From Here?

16 small hospital administrators take stock of themselves and their plans for professional advancement

"THIS is a very embarrassing questionnaire," writes a Texas hospital superintendent in response to an inquiry sent for the Small Hospital Forum. "It may not reveal much to you but it surely makes one take stock of himself. It will probably do us more good than it will you. Thank you."

That is an unusual response to any questionnaire survey. Another says: "This is the best I can do for you at present but I wish to thank you very much for the interest you are showing toward us."

This month's inquiry is a resurvey of subjects concerned with the administrator's personal advancement. One hundred copies were mailed to administrators of hospitals of less than 100 beds. Only 16 were filled out and returned. Are the other 84 also embarrassed?* Some of them doubtless are extremely busy, although it is hard to see how they could be any busier than one of the superintendents who did reply. An outline of his sixteen hour day is given later in this report.

A similar survey was published in the November 1941 issue of The MODERN HOSPITAL. Fourteen administrators replied that time. Readers may find it interesting to look at the earlier survey and compare results.

In the current report, nine administrators state that they have a professional library on hospital administration while seven do not. (Files of magazines alone were not included as a "library.") In three instances the books are owned by the administrator personally; in three instances, by the hospital, and in the remaining three cases, partly by each.

Fewer than 10 books are in the professional libraries of three respondents. Two have from 10 to 19 books, one has 25 and one has 30. Two failed to specify.

The Bacon Library committee of the A.H.A. has recommended a minimum library for hospital administrators of 12 books, which can be purchased for a total cost of $53.25, as indicated in the accompanying list.

1. The Hospital in Modern Society. Edited by Arthur C. Bachmeyer, M.D., and Gerhard Hartman, Ph.D. New York City: The Commonwealth Fund, 1943. Pp. 782. $5.

2. Administrative Medicine. Edited by Haven Emerson, M.D. New York City: Thomas Nelson and Sons, 1941. Pp. 839. $7.50.

3. Papers on the Science of Administration. By Luther Gulick and L. Urwick. New York City: Institute of Public Administration, Columbia University, 1937. Pp. 189. $3

4. Legal Guide for American Hospitals. By Emanuel Hayt and Lillian R. Hayt. New York City: Hospital Textbook Co., 1940. Pp. 600. $5.

5. Community Health Organization. By Ira V. Hiscock, Ph.D. New York City: The Commonwealth Fund, 1939. Pp. 318. $2.50.

6. Hospital Organization and Management. Second edition. By Malcolm T. MacEachern, M.D. Chicago: Physicians' Record Co., 1940. Pp. 1000. $7.50.

7. Hospital Public Relations. By Alden B. Mills. Chicago: Physicians' Record Co., 1939. Pp. 412. $3.75.

8. The Medical Staff in the Hospital. By Thomas R. Ponton, M.D. Chicago: Physicians' Record Co., 1938. Pp. 300. $2.50.

9. The Public's Investment in Hospitals. By C. Rufus Rorem, Ph.D. Chicago: The University of Chicago Press, 1930. Pp. 234. $2.50.

10. The American Hospital of the Twentieth Century. Third edition. By Edward F. Stevens. New York City: F. W. Dodge Corporation, 1928. Pp. 549. $7.50.

11. The Education of Nurses. By Isabel M. Stewart, R.N., M.A. New York City: The Macmillan Company, 1943. Pp. 399. $3.50.

12. Personnel Administration—Its Principles and Practice. Third edition. By Ordway Tead and Henry C. Metcalf. New York City: McGraw-Hill Publishing Co., 1933. Pp. 519. $4.

In addition, administrators of small hospitals would find extremely valuable the new book "Small Community Hospitals" by Henry J. Southmayd and Geddes Smith (New York City: The Commonwealth Fund, 1944. Pp. 182. $2).

It would have been interesting to find out the titles of the books in the administrators' libraries. Unfortunately, no question of this kind was asked.

If a hospital administrator or department head does not wish to purchase his own books, he can borrow them from the Bacon Library of the American Hospital Association without cost except for the nominal return postage. Only two of these 16 administrators regularly borrow books on hospital administration from this or any other library. These two report that their own libraries contain nine and 12 books, respectively.

Only six of the people replying have set aside a regular time for reading hospital magazines. Most of these read them in the evening. The amount of time devoted to reading such magazines each month varies over a fairly wide range.

Two people wouldn't hazard a guess; one spends less than four hours; three, from four to six hours; one, from eight to ten hours; three, from ten to twelve hours; five spend whatever time is necessary depending upon the content. One administrator spends twenty-four hours a month on eight different magazines which he classes as "hospital magazines." Doubtless, nursing, dietetic and other magazines are included.

With only one exception, all these administrators read both editorial text and advertising in the hospital magazines, although one other per-

*Since this was written two more replies have been received too late to be tabulated.

son states that his reading is "mostly editorial." This is indicative, of course, of the high degree of interest many hospital administrators have in the equipping and supplying of their institutions.

The number of hospital magazines that they "read systematically" varies from none (by an administrator who nevertheless devotes eight hours per month to such reading) to eight. One reads only one magazine; three read two; four read three; four read four; one reads five, and one reads "as many as possible." The last mentioned probably confused "issues" with magazines.

Only six of these administrators have attended any institutes in hospital administration. One of them, however, has attended three institutes and one is a gradaute of the University of Chicago course in hospital administration. Four are planning to attend an institute in 1944 or 1945 and two others say they may attend.

Majority Attend Conventions

Thirteen attend hospital conventions. Of the three who do not, one sends his assistant who handles most of the hospital's detailed administrative work. Only one person attends but one convention a year; six attend two; three go to three, and one goes to four. Two others have varying schedules.

Twelve of the administrators report that the hospital pays the expenses of attending institutes or conventions and two others say that the hospital does so in part or sometimes. In the two instances in which the hospital does not pay expenses, the administrators do not attend.

To indicate general cultural exposure, the administrators were asked how much time they have for general reading outside the hospital field. One reports no time at all available and another says only a limited time. Others report the following number of hours per week: one, seven (two administrators); four to five, 10½, 12, 14; "all I need" or "a great deal" (three administrators), and "too much; I read when I should do other things."

Membership in clubs and organizations shows the wide range of interests of these 16 administrators. Professional and business organizations mentioned are: district nurses' association, hospital council, American Nurses' Association, local, state, regional and national hospital associations, the American College of Hospital Administrators, National League of Nursing Education, American Public Health Association, anthropological and other biological associations, American Society of Foresters, Wildlife Society, Biological Society of Washington, National Audubon Society, Explorers' Club of New York, Lutheran Hospitals and Homes Society, Crippled Children's Association, educational associations.

Civic clubs mentioned include Lions, Chamber of Commerce, Women's Club, Rotary, Business Women's Circle of the Presbyterian Church, State Guard and Emergency Aid.

Social or cultural groups are: Eastern Star, Historical Club, Book-of-the-Month Club, Masonic lodge, Civic Music Club, Elks and, for only one administrator, the country club.

The amount of time devoted to such clubs and organizations varies from none for one administrator, very little for four, four hours per month for two, twenty-four hours per month for one to "all that is necessary" for three.

Gardening is the most popular recreation for the 10 administrators who mentioned their hobbies. Next come family life, golf and reading. Hobbies mentioned once include: collecting antique furniture, rifle practice (before the war diverted ammunition), bridge, needlepoint, horseback riding, fishing, theater, photography, painting, writing, skiing, mountain climbing in Wyoming and woodworking.

The number of hours a month available for recreation and hobbies are as follows: none, one administrator; up to 10 hours, four administrators; 20 to 29 hours, two administrators; 30 to 59 hours, three administrators; 60 hours and over, one administrator. Several others were not able to give definite answers on this subject.

"Do you have a personal professional goal that you expect to reach 5, 10 or 25 years hence?" This question brought 11 affirmative answers and one answer from an administrator who has already achieved her goal, namely, graduation from the University of Chicago course in hospital administration.

Two administrators aspire to fellowship in the A.C.H.A. and two others wish to make some substantial contribution to the science of hospital administration. Two others apparently have rather similar ambitions which they express as "to become good hospital administrators."

Other goals mentioned once each are: "To maintain the standards of this institution during the war and later to retire to a home of my own." "To serve as much longer as I can be effective (having served twenty-five years already) and then retire and see that my adopted daughter is launched in a profession." "To own a hospital of my own." "To progress further in biological research." "To complete a reconstruction hospital in this state with orthopedic, plastic and general surgery that will give postgraduate courses in these subjects." "To have a bigger and better hospital with a working surplus."

In order to turn the tables, the final question gave the administrators a chance to air their own pet "peeves." This question reads: "What help would you like to receive from hospital journals and hospital associations in working toward your personal goal?" Nine failed to answer and two others report that present help is satisfactory.

Specific suggestions are: more short institutes and conferences more readily available (a Maryland administrator), reports of the experiences of other hospitals in meeting everyday problems, information regarding reconstruction surgery, rehabilitation and care of industrial accidents, information on group medicine and its possible postwar development, architectural plans, direct questions and answers.

Life of an Administrator

This inquiry brought forth several interesting statements that give a good picture of the life of the superintendent of a small hospital. One woman writes:

"I have been at the head of a hospital for many years. I have raised two children; one is a hospital superintendent and the other has spent fifteen months in the South Pacific as a nurse. I have a grandchild who is with me for health reasons and is in the third grade. I keep house and raise flowers for my home and neighbors. There are many activities around our home. Last but not least I have a husband who is a dentist and I try to enter into his social activities.

"Yes, I'm busy but I like it all. If I can get this A.C.H.A. fellowship, I'll think I have reached my goal but no doubt there will be something else to strive for. I have helped plan one new hospital and move into it and am now planning a nurses' home and an addition. I have received much help through the hospital journals."

The biologist, whose answers were readily apparent earlier in this report, explains that his principal work is with the federal government in biological research. He accepted the superintendency of the small local hospital as a community service and exercises general supervision, policy formation and purchasing. "I rely on my assistant superintendent and chief nurse for the more intimate details of day-by-day administration."

That administrators in small hospitals carry heavy loads is indicated by the reply from a man in a midwestern state. "The duties of an administrator of a small hospital are so multitudinous that it is almost impossible to belong to such clubs as Kiwanis and Rotary. If a person joins such an organization he should be in a position to contribute at least some time and effort. A brief summary of a typical day will give you some idea as to what I mean.

"I get up every morning at 6. By 6:30 I am at the hospital and eat breakfast. Between 7 and 9:30 I generally read some medical or hospital journal and make a general inspection of the hospital. The morning mail arrives at 9:30 and I immediately go through it and take care of urgent correspondence. Since I am responsible for collections in this hospital, that item alone requires a great amount of letter writing.

"Salesmen generally come between 10 and 12 and, since I do all of the buying, I am busy with them the rest of the morning. In between, if an emergency comes to the hospital, I do the 'prep,' if it is a male patient, because we have not been able to employ a satisfactory orderly.

"I eat dinner from 12:30 to 1, after which I generally take a deposit to the bank which is 2 miles from the hospital. While downtown I generally pick up some purchases and practically every day stop in to see the president of the hospital board and the county clerk, to whom I must submit all claims for payment since this is a county hospital.

"Upon returning to the hospital I spend the rest of the time until 6 writing business letters. I also advise and assist the engineer in his work, which includes carrying garbage cans, softening water, taking care of plumbing, heating and electrical work and redecorating of the entire hospital. Sometimes I am also called upon to assist the doctors in setting fractures when no one else is available.

"After 6 I generally go home and eat my evening meal between 6:30 and 7. At 7:30 every Monday I attend state guard as a technical sergeant in the chemical warfare division. Not only do we drill but I give instructions in chemical warfare and first aid.

"Arriving home at 10, I am tired after a sixteen hour day. After listening to the news from 10 to 10:15 I go to bed and generally read the newspaper or some book or hospital magazine until 11:30.

"There you have a typical day. Such a day gives me little time to spend with my wife and four children who range in age from 8 to 17. However, I make up for this during other evenings of the week when I attend their school and other affairs.

"Practically every week I speak at noon luncheons of Kiwanis, Rotary, Eagles or some other organization. Then there are the meetings of the committee on Red Cross volunteer nurse's aides, the board of the Associated Hospital Service, meetings every two weeks of the state committee on Procurement and Assignment of Nurses, meetings of the board of the state hospital association and others too numerous to mention.

"I love to golf, hunt and fish but in times like these I must forego such pleasures. Anyway, I get plenty of exercise doing my daily duties as administrator of a 55 bed hospital. Cheerio!"

WOMEN'S SERVICE GROUPS

Specialize in Student Needs

Easter plants and Easter boxes of candy for the wards are perennial presents from the women's auxiliary of Grace Hospital, New Haven, Conn. Besides its considerable sewing assistance to the housekeeping department, this auxiliary contributes wholeheartedly to school of nursing projects. It buys card tables, has the piano tuned, keeps the radio in order, arranges the swimming and basketball program at the local Y.W.C.A., provides funds for parties, buys books and magazines for the reference library, provides the commencement decorations, gives a tea for the senior class and hospital staff, awards prizes to students and generally sees to it that the student nurses' lives include some play and are not all work and study.

Auxiliary Guides Visitors

All reception service during hospital visiting hours at Eastern Maine General Hospital, Bangor, is provided by the women's auxiliary, membership in which has reached 500 or more. These loyal workers are unceasingly active, providing garments for the pediatrics service and underwriting many projects. The nursing school is a special pet of the auxiliary with the nurses' graduating exercises getting much attention; also provided are two annual awards for outstanding members of the graduating class.

Cited for Service

An early arrival in the dietitian's aide field was a group of volunteers at Silver Cross Hospital, Joliet, Ill. In consequence, this canteen corps had given 3166½ hours of service to the hospital up to March 1. Fourteen of these aides received "Citations for Meritorious Service" recently at the same time that a large group of Silver Cross nurse's aides won citations at a testimonial dinner given all of the hospital's volunteers by the board of trustees. A total of 18,164½ hours of volunteer service was reported.

To the Workers

Don't you like the idea of putting the occasional spotlight on the volunteers rather than on the women's board or officers of the auxiliary?

This was done recently at Atlantic, Iowa, when the Atlantic Hospital, wishing to give public recognition to its nurse's aides and Gray Ladies gave a dinner for them and their husbands at a local hotel.

The address of appreciation was warmly put but short, the responses were brief and the group singing was only a little longer.

A news photographer came and took pictures—of the volunteers. The local newspaper wrote up the dinner, mentioning the names of the volunteers. The party was given in their honor and the honors all went to them.

Safeguards for the Mentally Ill

Are Your Patients Protected

Against burns or scalds?

Against tripping and falling?

Against sharp instruments and glass?

Against pollution of the water system?

Against flies—roaches—other vermin?

Lt. SOL A. ROBINS, M.C.

Neuropsychiatrist, 147th Station Hospital
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HOSPITALS and institutions devoted to the care of the mentally ill usually house a number of psychotic chronically ailing patients who cannot think for or safeguard themselves. Such hospitals, because of their location, large acreage and floor space and special setups for occupational therapy and recreational activities, present problems that are essentially different from those prevailing in other types of hospitals.

The medical officer on duty here has an unlimited opportunity to think and work, plan and prepare for the greater safety of the patients delegated to his care. Following is a list of the safety measures that should be kept constantly in mind by officials of mental disease hospitals.

■ To prevent tripping and injury from falls, infirm patients should not be required to use stairways. This particularly applies to patients classed as paretics, tabetics and epileptics who should be quartered on lower story wards so that they can go to meals, outdoor exercise and occupational therapy projects with less hazard to themselves.

■ Stairway shafts should be checked for adequate lighting. Additional lights should be so placed that they will not dazzle the eyes.

■ Operation of elevators should be consistent with safety at all times. Doors leading to elevator shafts must be securely closed except when in actual use. Tampering with the doors by patients should be prohibited.

■ Sloping and slippery sidewalks, holes and defects in pavement leading to the various buildings should be eliminated and repaired as soon as feasible. Concrete floors torn up for repairs underground should be completed promptly in locations that are frequented by patients.

■ Fire drills are a useful and necessary part of the hospital routine. However, speed of evacuation of the inmates from a dormitory or day room is secondary to safety. Panic, confusion and falls are to be avoided at all costs and special care is to be given to disabled patients, *i.e.* those with artificial legs and impaired eyesight. Exposure to draft and neglect in matters of attire and footwear during drill are additional points to bear in mind.

■ Elimination of fire hazard from carelessly thrown cigaret butts requires that a number of receptacles of fireproof construction be placed in conspicuous spots. Such receptacles may also serve as cuspidors to eliminate, if possible, careless expectoration by the patients on the floor.

■ Radiator grilles to cover and enclose radiators should be installed to protect from burns and scalds. Steam pipes and radiators are sources of trouble when they leak hot water or steam. Occasionally, too, loudly transmitted noises are heard through the medium of steam pipes which, particularly at night, interfere with rest and sleep. All such should be reported and promptly eliminated.

■ The continued operation of drinking fountains, wash basins, water faucets and flush toilets is obviously of vital concern, as is the hot water supply. Is the water too hot so that there is danger of scalding? Or is it not sufficiently hot so that there are delay and inconvenience in the daily routine?

■ The sanitary condition and sterilization of the implements employed by the barber should be inquired into and supervised at all times. Razor blades should not be permitted to find their way into the patients' hands, nor should knives and other sharp instruments. In some hospitals patients are searched daily for such unauthorized articles, particularly after meals.

■ The source and potability of the drinking water on the hospital reservation should be a matter of inquiry. The color, taste, chlorination method, if any, and analysis of water samples must be carefully watched.

■ Weekly inspection of buildings and grounds to cover storerooms, lavatories and attendants' quarters is of considerable value. If carried out properly it may bring to light a number of points and measures to be taken in the interest of the patients' safety.

■ Particularly important is the sanitary inspection of kitchens and mess halls to forestall contaminating of foodstuffs that might result in epidemics of food poisoning in an institution. The adequacy of refrigeration of cooked and uncooked foodstuffs is a proper part of the inspection of kitchens.

■ Periodic checkup of refrigerators should be insisted upon. Leaking ammonia from refrigerators can cause nasal irritation, headache and even partial asphyxia of kitchen personnel and patients.

■ Cleanliness of all utensils should be insisted upon. Milk cans and other receptacles, especially those delivered by a contractor, should be subject to scrutiny. If there are tuberculous patients separate sterilization of food dishes should be the order of the day.

■ Left-overs from the general mess are collected in cans which are kept in refrigerated storage until they are carted away for disposal. The prescribed temperature in this refrigerator should be checked. Under no circumstances should such remains be left overnight outside the cans or uncovered. The cans should not be leaky and there should not be any spilling in the process of filling them.

■ Roaches are a disgusting and persistent pest and are invited by food remnants and unclean utensils. An officer of the day can discover them in his night rounds by the use of a flashlight. Once roaches are allowed to multiply their complete eradication becomes exasperatingly difficult. No one insecticide is wholly effective, although a large number are guaranteed to do a thorough job of extermination. Sodium fluoride powder is the most satisfactory agent, but it is poisonous and should not be used where psychotic patients can get at it.

■ Meat purchased in the open market for use in the dietetic department should be checked for the meat inspector's stamp of approval. When hogs are raised and slaughtered on the reservation, the fresh pork should be grossly examined and approved by the medical officer before carting to the dietetic department. No inspection, however, excludes the possibility that trichiniasis or other parasitic infestation is present so that proper cooking until the pork is white should be insisted upon.

■ The cans in which the edible left-overs of the mess are delivered to the farm or contractor, after being emptied, should always be scalded with hot water and cleansed inside and out before returning to the kitchen for the next shipment.

■ It is surprising how fruitful a sanitary officer's tour of inspection will be if he but takes the trouble to look at the rear of buildings and visit the confines of the reservation. As a rule, it is in such places that trash is allowed to accumulate.

■ Policing of the grounds and lawns, particularly those adjoining the ward buildings, is of more than esthetic value. A number of unauthorized objects, such as nails, wires or other trinkets that are easily swallowed by and potentially harmful to psychotic patients, may be discovered. All these, as well as match covers, cigaret butts and the like, should be picked up regularly.

■ Enclosures for garbage or trash cans are required to be flyproof, but the inspector should satisfy himself that they are truly so. Such enclosures should have no vents or openings to the exterior and their doors must fit tightly.

The cans inside the enclosure should be covered at all times, and cans that are too misshapen through wear and tear should be discarded as they are not then flyproof. Spilling of the garbage in the process of hauling should be cautioned against and the floor of the enclosure should at all times be free of spilled material.

■ The site designated for the disposal of collected garbage and trash is to be visited from time to time. Here the material delivered must be effectively destroyed. The garbage is to be incinerated and care should be taken to reduce it to ashes. Partly destroyed refuse and material subject to slow decomposition should not be tolerated. Only if all garbage is completely incinerated can offensive odors, flies and rat infestation be kept down to a minimum. The available space should be utilized with economy.

■ The sewage disposal plant, its condition, capacity and the method employed for the disposal of liquid wastes should be inquired into and its operation checked at intervals. The cesspool and pond and the latter's reserve capacity for future deposits are items for attention.

■ In the summertime foot hygiene of the patients must never be neglected and will be found a challenge to the ingenuity of a resourceful physician. There is a widespread misconception that the prophylaxis and therapeusis of perspiring, malodorous feet is frequent bathing with soap and water. Ringworm infection, particularly in institutions and among patients who cooperate poorly, is difficult to control. Its incidence, as a rule, is greatest on parole wards and among patients engaged outdoors. In this connection, chlorination of water in the swimming pool, if any, is not to be neglected.

■ Elimination and destruction of ragweed in late summer are an effective aid in the purification of air from pollen during the hay fever season. Tracts of land adjoining the reservation and overgrown with ragweed should be weeded out and then burned.

■ Winter brings problems different from those prevailing during the warm months. Before the onset of cold weather a sufficient quantity of protective clothing for all patients, but more especially those assigned to outdoor occupations, must be stocked. This consists of blazers, overshoes, mittens, winter caps and the like.

■ The various buildings require conditioning for the cold weather. The gymnasium should be prepared so that it can meet the heavier load of indoor sports and calisthenics classes. The recreation hall and motion picture theater will see a greater attendance.

■ Hallways and corridors frequented by patients, their windows, the heating system, ventilation and air conditioning require consideration.

■ Inclement weather may necessitate keeping the patients indoors; hence, there should be a sufficient quantity of furniture, of the type authorized in all the dayrooms.

■ Overcrowding of dormitories should be avoided in the interest of ample ventilation. Extra beds are not to be placed in inner corridors or alcoves.

■ Speed limits for vehicles on the reservation grounds must be enforced and attendants accompanying patients about the grounds should be cautioned about dangerous intersections.

TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

Public Relations

from the doctor's point of view

WALTER G. PHIPPEN, M.D.

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Salem Hospital, Salem, Mass.

A HOSPITAL is made up of three equally important parts—the trustees, the administration and the medical staff. No one or two of these can function without the third. The relationship among these groups should be cordial and entirely cooperative. All these groups have a definite contact with the public but of the three, the doctor probably has the greatest opportunity as he comes in daily contact with innumerable patients and their families and friends both within and without the hospital.

What an opportunity he has to interpret the work, the ambitions and the needs of his institution! Yet many doctors are diffident about doing this. In fact, they are often criticized by trustees and directors for their seeming lack of interest.

The Patient Comes First

In most instances their diffidence does not arise from lack of interest. It is rather lack of thoughtfulness and perhaps a little lack of stimulation. Remember that the doctor's first thought is the medical care of the patient. That transcends all others.

What can the trustees and administration do to make further use of this potential power? Perhaps most important is to take the staff, as much as possible, into their confidence. This does not mean that every act of the board of trustees should be submitted to the staff nor that a member of the active staff should sit on the board. This is now generally recognized as a poor principle and likely to lead to difficulties.

A definite liaison should be set up between the board and the staff, through an intermediate body—an executive committee, staff council or what you will—consisting of elected staff members and the director of the hospital. This group should not be too large for members to get together quickly but large enough to be really representative. It should hold frequent meetings and enjoy free and frank discussion.

At such meetings criticisms by patients, doctors, the nursing force or other departments can be harmoniously discussed, to the benefit of all. Here, also, new policies relating to the admittance of patients, use of the out-patient department, new clinics, increased prices for rooms and other services can be interpreted by the director.

Intern problems and the qualifications of new staff appointments also come within the scope of this group. Frank exchange of ideas and opinions in these meetings will prevent many unpleasant episodes that weaken the esprit de corps of a hospital and, thus, its appeal to the public.

An occasional informal meeting of the trustees and the staff is extremely helpful. Only a few speeches should be made and the rest of the time should be given over to a discussion of problems. The staff members will be stimulated and some of this enthusiasm will, in turn, be transmitted to the public.

A question the business man usually asks is why it costs so much money to run a hospital. Accustomed to dealing in profit he can't understand dealing in service. Trustees and directors can explain the business details, show him where the money goes, but can they explain as well as a doctor why the money goes?

We can say, for instance, that we need more room for the laboratory because, whereas twenty years ago one room for one technician was quite sufficient, now we must find room for a full-time pathologist, a resident in pathology, a secretary and perhaps six or eight technicians. The public will probably answer: "That's a very good reason, but why the increased personnel?"

The Doctor Knows the Answer

The doctor can help there by explaining that the laboratory has become more and more necessary because of the tremendous increase in scientific medical knowledge in a short period. Not so many years ago we would perform what we thought was a pretty good technical operation but the patient died and we didn't understand why.

Now we know that a proper understanding of the chemistry of the body and of methods of making up deficiencies in any of its elements has saved many lives. But the estimation of the levels of chlorides, proteins and nitrogen requires many careful laboratory procedures. This requires costly equipment and increased personnel.

Radio broadcasts constitute a valuable form of publicity and one in which the doctors can easily cooperate. In Salem, Mass., we have had this opportunity ever since last fall through the courtesy of Station WESX. The broadcast is made easily from the conference room in the hospital at 10:30 every Tuesday morning. The assistant director arranges the panel and sees that the script is in order. All departments are invited to take part, including the medical staff and interns.

Up to the present time we have

From a talk before the New England Hospital Assembly, Boston, March 1944.

made about 40 broadcasts and many members of the staff have willingly participated. Once a month the period is devoted to a health talk by a staff member. We have received many commendatory letters and radio broadcasting as a publicity measure in which the medical staff can be most useful can be heartily recommended.

Another way in which the doctor can help to maintain good feeling in the community toward the hospital is to give adequate and careful instruction to the patient on discharge as to his future course, how much activity he should enjoy, what his diet should be and when he should go to work. Often patients are discharged hurriedly without adequate advice so that they feel all at sea and much of the good work accomplished in the hospital goes for naught and the hospital gets the blame.

Make Use of Social Service

If the patient was referred by a physician not on the staff, a letter or telephone call referring the patient back will help immensely. If he should return to the out-patient clinic the proper liaison between the house and the clinic staffs accomplishes the same thing. The proper use by the staff of a well-organized social service department is most important.

Before the war public lectures on Sunday afternoon offered an excellent opportunity for staff members to present the work of the hospital. These should be given at the hospital. If they are given in a public hall they may command a larger audience but the connection with the hospital is largely lost. Many hospitals have conducted such courses and, in general, they have been well patronized.

Another important contact with the public is through the hospital aid societies, or whatever they may be called. These women's auxiliary groups usually have regular meetings and it is not difficult to make a place for a member of the staff on the program to explain some activity of the hospital. At Salem Hospital we are doing some experimental, and perhaps somewhat original, work on the RH factor and our pathologist was able to give the auxiliary an interesting lecture on the subject. Of course, all of the members didn't understand everything that was discussed but they carried enough away to tell their friends something about it. This helps to drive home the idea that the hospital is not just a receptacle for the sick but that it is a really scientific institution.

Red Cross nurse's aides constitute a potential power for good will for the hospital. The staff doctor comes in daily contact with many of them. His courtesy, consideration and cheerful recognition will do much to make them feel that they are a necessary and useful part of the hospital and will thereby enhance its prestige.

A hospital is an integral part of its community. It is as necessary as the police or fire department and the community should recognize its responsibility for its support. On the other hand, the hospital should recognize its responsibility to the community, which is to furnish the highest quality of medical service possible within the limits of its resources and to be ever pushing forward to greater achievement. This presupposes an efficiently organized medical staff with proper laboratory and x-ray facilities, clinical records and the proper use of case histories in clinical conferences.

It is not so generally recognized, by the public at least, that the better and more efficient these facilities are, the greater the incentive for young medical graduates to settle in the community. A hospital appointment is becoming more and more necessary and graduates look the hospital situation over carefully before deciding where to start their practice. One or two full-time men, such as a radiologist, pathologist or an anesthetist, form a good nucleus for such an organization.

All hospitals, however, cannot maintain such an organization because some are too small and have too little clinical material. Hospitals of less than 100 beds have this difficulty, yet they serve a useful purpose in their communities. They cannot be expected to provide equipment for elaborate surgical or medical procedures or furnish adequate laboratory and x-ray facilities. It is often possible for these small hospitals to cooperate with some larger and better equipped institution to the mutual advantage of both.

Periodic laboratory and x-ray service can be furnished by the large institution. Complicated medical or surgical cases can be transferred from the small hospital without prejudice if its staff is given appropriate appointments at the large hospital.

A moderately large publicity committee recruited from outside the personnel of the hospital, meeting at regular intervals, is an excellent idea. This committee should invite one or two of the staff members to attend its meetings and explain the work of the various departments. Such talks will enable the committee to interpret the work of the hospital more intelligently.

Finally, in considering the doctors' rôle in public relations it is important to bear in mind the sacred doctor-patient relationship. This relationship properly used is a great power for good but improperly used may be a great power for evil.

Criticism Can Be Avoided

If a doctor thoughtlessly agrees with his patient in some trivial criticism, without knowing the true facts, an unpleasant feeling may result that will take years to eradicate. Whereas, if he takes the trouble to get the details he may be able to explain away the difficulty in five minutes. One may say that this represents the personal equation of the doctor and that not much can be done about it. I disagree. A great deal can be done about it.

In the first place a good staff organization helps a lot. A comfortable chat with the chief of staff may be all that is necessary if the time and place are well chosen. The middle of a noisy corrider is not the right place, neither is the surgeon's room in the operating building. A quiet library is better. Sometimes a more formal approach in the director's office may be advisable.

Staff members must be made to feel that every criticism will receive polite and thoughtful reception. The doctor must leave the director's office with the feeling that everything possible will be done promptly to clear up the situation.

To sum up, if the hospital will enlist the confidence of the medical staff, understand the various peculiarities of its members, be patient with their idiosyncrasies and lend them ever a sympathetic ear, it will have their hearty cooperation in all undertakings.

—Geriatrics Series—

Physical Therapy
comes to the aid of the aged

Part I

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THE conditions of old age offer especially favorable opportunities for the application of physical therapeutic agents. While many diseases are inevitable and little amenable to treatment, much can be done to make these people reasonably comfortable and happy in their remaining lifetime.

The progressive age changes not as yet known to be due to specific disease, listed by Carlson,[1] are tissue desiccation, retardation of cell division, impaired capacity for tissue repair, slowing of the rate of tissue oxidation, atrophy of cells without fatty infiltration, decrease of elasticity of connective tissue, diminished speed, strength and endurance of neuromuscular reactions, impaired strength of skeletal muscles and degeneration and atrophy of the nervous system. Because of the anatomic changes in tissues and organs in the aged, the function is altered, but the functional changes do not always correspond to the anatomic changes.

Sensory Perception Blunted

Of special importance in physical therapy are the atrophy of skin and blunting of sensory perception. As a result of curtailed response of various organs, an aged person cannot tolerate the application of physical agents as well as a younger person. Therefore, geriatric physical therapy must be conservative and must be applied with the idea of preserving and strengthening bodily functions, as well as counteracting the processes of disease.

Arthritis is widespread in old age and, though seldom the cause of death, it ravages efficiency and health, provokes pain and discomfort and impairs bodily mobility, the prime requisite of human freedom. Although it ranks low as a cause of death, it ranks first in prevalence of chronic disease in the United States.[2]

Chronic articular disease chiefly comprises rheumatoid arthritis (atrophic chronic infectious arthritis) and osteo-arthritis (hypertrophic, degenerative joint disease). Osteo-arthritis is the commoner of the two, but rheumatoid arthritis is fairly common. Degenerative changes are demonstrable in every person well in advance of his sixtieth year.

Rheumatoid arthritis in the simplest terms is an inflammatory synovitis that soon affects other articular and periarticular structures. The joints most often affected are the peripheral joints, such as wrists, fingers, elbows, knees, ankles and toes. There is usually some destruction and fibrous or bony ankylosis may develop.

Trauma, use and weight-bearing do not have any relation to the site of involvement, but they may intensify the process once it has started. It usually produces certain constitutional reactions typical of a long-standing infection, such as weakness, loss of weight, hypochromic anemia, rapid pulse, elevated sedimentation rate, fever and muscular atrophy.

The term "osteo-arthritis" is synonymous with "degenerative arthritis," "primary hypertrophic arthritis" or "senescent arthritis." Osteo-arthritis is primarily an aging process with inflammation secondary. Hypertrophic changes visible in the roentgenogram may appear in many forms of arthritis, especially in the joints that bear weight, according to Hench.[3]

Senescent arthritis usually affects fingers, knees, shoulders, hips and the lumbar and cervical portions of the spinal column. The course of the disease is variable and the symptoms may not correlate with the amount of pathologic change found. Constitutional reactions are largely or entirely absent. Ankylosis is not a feature.

Treatment Prevents Local Changes

Physical measures have been employed since ancient times in the treatment of chronic arthritis. General measures may serve as a part of the constitutional treatment for increase of circulation and metabolism and, applied locally, physical treatment serves to prevent and relieve local arthritic changes: pain, stiffness, exudation, muscular atrophy and weakness.

In the acute stage rest is of the greatest importance. This may be either general or local, depending on the severity of the process and the parts involved. Applications of heat, as recommended by Krusen,[4] are of special value even during an acute onset or during acute exacerbations.

Local heat can be administered in many ways: dry, wet or with diathermy. One of the most convenient methods is the use of a simple heat lamp, as described by Krusen,[5] or an inexpensive baker which consists of a number of bulbs under a U-shaped reflector. If electricity is not available, heat can be applied by the use

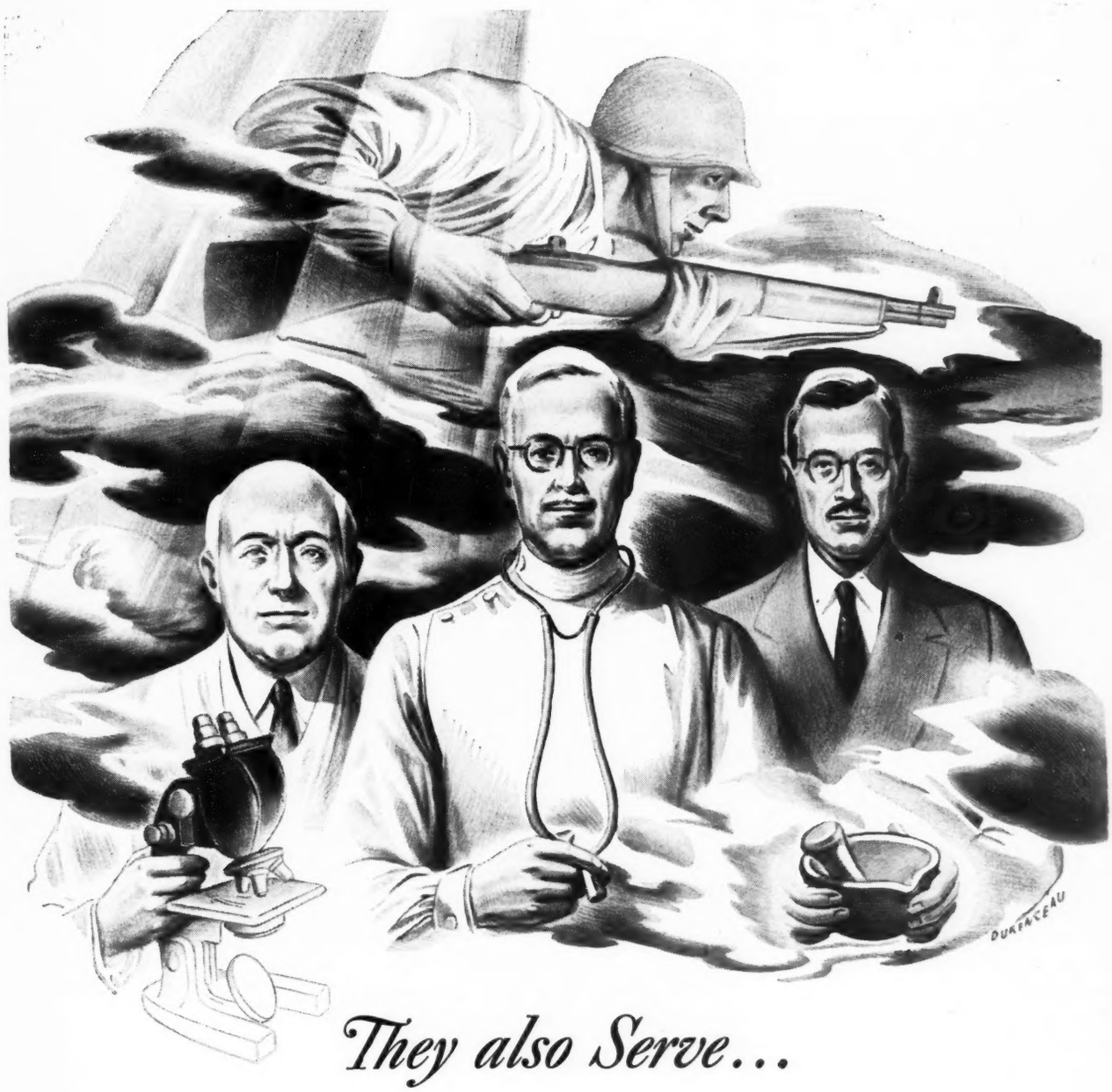
[1]Carlson, A. J.: The Physiology of Aging, Northwest Med. **42**:6-13 (Jan.); 46-48 (Feb.) 1943.

[2]National Health Survey, 1935-1936: Sickness and Medical Care Series, Bulletin No. 6, National Institute of Health, U. S. Public Health Service, U. S. Government Printing Office, Washington, D. C. Revised 1939.

[3]Hench, P. S.: Chronic Arthritis. In Barr, D. P.: Modern Medical Therapy in General Practice, Baltimore, Williams & Wilkins Company, 1940, vol. 3, pp. 3298-3397.

[4]Krusen, F. H.: Physical Medicine; the Employment of Physical Agents for Diagnosis and Therapy, Philadelphia, W. B. Saunders Company, 1941, pp. 846.

[5]Krusen, F. H.: Simple, Inexpensive Heat Lamp, J.A.M.A. **107**:780 (Sept. 5) 1936.



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of hot paraffin (Figs. 1 and 2), hot fomentations or conductive heating devices, although the last named are not as effective or as safe as other methods.

Contrast (alternate hot and cold) baths are used effectively for the hands and the feet. Also, general exposures to heat are made easily by means of simple hot tub baths, which may be administered in the patient's bathtub. However, older people should be cautious in the use of prolonged hot tub baths.

Massage alone is not very helpful. It should follow the use of heat and be followed by active and active assistive motion. The type of massage most useful in chronic arthritis is a sedative type consisting of light to deep effleurage (stroking) and light to deep pétrissage (kneading) proximal and distal to the involved joint and only light stroking over the joint.

It is possible for the patient to use massage at home, preferably with the help of a member of the family. It can be taught in one or two lessons so that it can be used for a prolonged period at home.

Exercise of the involved joints is important to prevent the formation of fibrous adhesions in the joint and to decrease the tendency to atrophy of the surrounding muscles. One or two daily painless movements of the joint will usually prevent the formation of dense adhesions. It is well to remember that, as pointed out by Hench, one movement through the full range of motion is better than a series of shorter movements.

Patients should be taught the general rules of exercise: (1) an amount of exercise that does not produce any pain or increase of pain during or after administration is obviously tolerated and can be continued; (2) an amount of exercise which produces a little pain or a slight increase of the pain but which does not increase disability afterward is also probably harmless; (3) exercise that is followed by increased disability either immediately or after a time is harmful and must be discontinued.

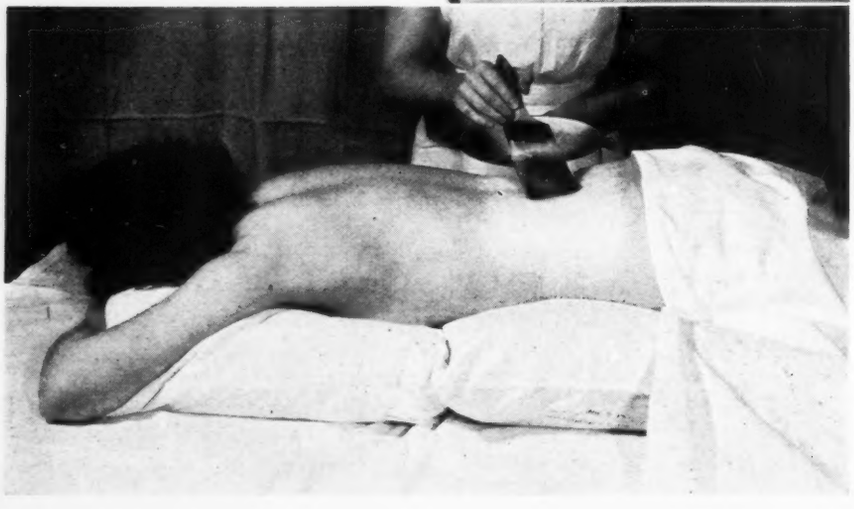
Over-exercise can provoke an exacerbation of the rheumatoid variety and is harmful and irritates the process of osteo-arthritis. In general, a combination of rest and exercise is prescribed, with emphasis on rest.

The enlarged terminal interphalangeal joints of the hands in osteo-arthritis frequently show smooth nodules, which are named Heberden's nodes. When these joints are painful and tender, the use of contrast baths or paraffin packs is beneficial.

Osteo-arthritis of the hip (malum coxae senilis) is the most disabling form of osteo-arthritis, according to Comroe.[6] It is usually bilateral but one hip is more involved than the other. The degenerative changes result from the head of the femur grinding down the acetabulum. The acetabulum becomes shallow and the femoral head wears away. There is progressive loss of articular motion accompanied by a limp. The pain is aggravated by motion and weight-bearing.

FIGURE 1

FIGURE 2



The use of heat, sedative massage and active assistive exercise will be beneficial in many cases for symptomatic relief and to increase the range of motion. When a cup arthroplasty operation is performed on the hip, physical therapeutic measures are of great value in restoration of all possible joint function, as described by Smith-Petersen.[7]

Osteo-arthritis of the knees is common because weight-bearing hastens degeneration and the ligaments are often strained by use. Frequently, the patella is most affected. According to Haggart,[8] palpation during motion elicits crepitation beneath the patella and passive motion of that bone is often painful. The regular use of heat, massage and a well-fitted one-piece elastic knee support or a properly applied roller elastic bandage frequently gives much relief. Reduction of trauma is important, including reduction of trauma of obesity to weight-bearing joints.

Osteophytes commonly involve the vertebrae, generally in the lower cervical and lower lumbar regions. Symptoms depend on the region involved. Cervical lesions may produce radicular pain in the shoulder girdle, arm and thorax. Changes in the lumbar vertebrae may be reflected in pains in the leg, especially referred along the sciatic nerve.

When changes are in the cervical vertebrae a special technic of neck stretching described by Hanflig[9] is particularly useful. A Sayre head sling is applied to suspend the head and, while traction is being applied, the head is rotated forcibly in both

[6]Comroe, B. I.: Arthritis and Allied Conditions, Philadelphia, Lea & Febiger, 1940, pp. 752.

[7]Smith-Petersen, M. N.: Arthroplasty of the Hip; a New Method, J. Bone & Joint Surg. n.s. **21**:269-288 (April) 1939.

[8]Haggart, G. E.: The Surgical Treatment of Degenerative Arthritis of the Knee Joint, J. Bone & Joint Surg. n.s. **22**:717-729 (July) 1940.

[9]Hanflig, S. S.: Pain in the Shoulder Girdle, Arm and Precordium Due to Cervical Arthritis, J.A.M.A. **106**:523-526 (Feb. 15) 1936.

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FIGURE 4

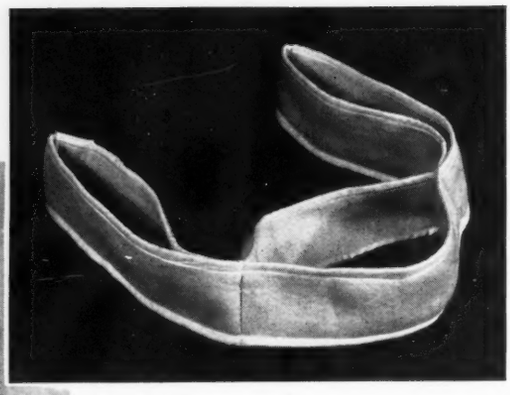
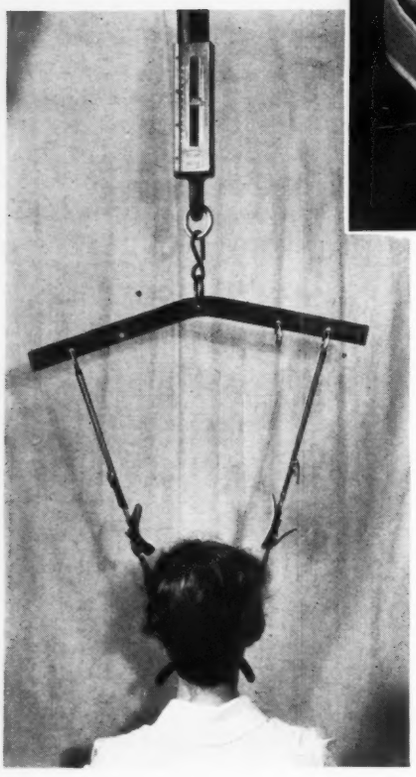


FIGURE 3



directions (Fig. 3). This maneuver should be preceded by the use of heat and massage.

If this is helpful, the patient can be instructed in home use of a simple flannel head sling (Fig. 4) that can be hung from a door frame, as pointed out by Martin.[10] Teaching of correct posture is important so that bodily mechanics can be improved, especially in respect to the lumbar lordosis and forward bowing of the thoracic portion of the spinal column. In addition, the use of supports in the form of corsets or belts is of great benefit for low back discomfort.

Backache from senile osteoporosis is accounted for on the basis of the deformities of the bones. It is commoner among women than among men. The treatment aims to replenish the calcium and phosphorus in the bones, besides correction or prevention of deformities. The local application of heat and massage is indicated as is ultraviolet irradiation in addition to the oral administration of cod liver oil and calcium. Postural exercises should be carried out and the back should be supported with a high back corset, stays or a brace.

Muscular rheumatism or fibrositis is really not a form of arthritis, as pointed out by Slocumb,[11] who outlined the differential characteristics. It is an inflammatory disease involving the fibrous tissue of fasciae, aponeuroses, sheaths of muscles and nerves, ligaments, tendons, periosteum or subcutaneous tissue. It has been classified by most authorities into (1) primary, independent of pathologic causes elsewhere in the body; (2) secondary, a pathologic process, and (3) senile, which may be a degenerative process accompanying senescence.

In old age the process is insidious. Symptoms include aching and stiffness (jelling) of muscles or joints which is worse after a period of inactivity and better after a period of moderate activity. According to Thewlis,[12] fibrositis frequently accompanies osteo-arthritis. Usually, palpable tender indurations are found in muscles and fasciae.

Physical therapy is of great value in treatment of fibrositis. In the early stages heat applied locally is indispensable for relief. In the later stages the specific treatment is massage designed to break up the nodules, as was pointed out by Krusen, who also noted that non-nodular portions of the painful muscles may also require treatment.

Slocumb stated that "the usually accepted treatment is physical therapy with firm massage for a long period of time and removal of foci to prevent recurrences."

It is wise to precede and to follow the heavy massage with sedative type of massage to promote muscular relaxation and to hasten absorption. Exercises are helpful for prevention, as stressed by Thewlis. They should be moderate.

Unaccustomed activities should be avoided, for example, heavy lifting, mountain climbing or sitting for prolonged periods in an uncomfortable position. Attention should also be given to proper clothing, adequate rest and avoidance of exposure to cold or sudden changes of temperature.

Painful shoulder is commonly encountered among older people, although it is not restricted to this age group. Comroe stated that a painful shoulder alone, without any evidence of articular disease in any other part of the body, is seldom caused by arthritis and that probably 80 per cent is due to subdeltoid bursitis.

According to Hench and his associates,[13] inflammation of the bursa rarely occurs primarily but almost always as a result of lesions in contiguous tissues. In these tissues attritional changes occur, with or without deposition of calcium salts in middle age. It is probable that trauma is an important factor, according to Codman,[14] who expressed the belief that bursitis is associated frequently with traumatic degenerative lesions of the supraspinatus tendon.

Symptoms include pain and tenderness in the region of the shoulder, especially over the greater tuberosity of the humerus and near the insertion of the deltoid muscle. There is usually limited motion, particularly abduction and rotation of the shoulder.

The regular application of heat, massage and exercise help to relieve pain and shorten the disability. Krusen suggested the application of conventional diathermy because this method gives better localization of heat. Other forms of heat are useful. Occasionally, cold must be substituted if heat aggravates the pain. Exercises should be increased as the condition improves, in order to improve the mobility of the joint.

Traumatic lesions must be treated with the usual orthopedic measures.

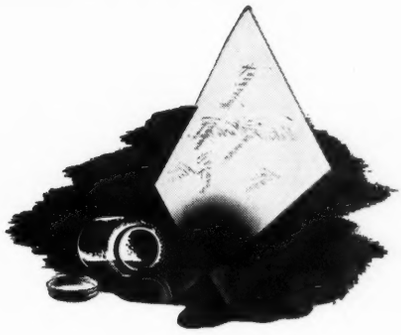
[10]Martin, G. M.: Radicular Pain and Its Physical Treatment, M. Clin. North America (July) 1943, pp. 994-1006.

[11]Slocumb, C. H.: Differential Diagnosis of Periarticular Fibrositis and Arthritis, J. Lab. & Clin. Med. **22**:56-63 (Oct.) 1936.

[12]Thewlis, M. W.: The Care of the Aged (Geriatrics), Ed. 3, St. Louis, C. V. Mosby Company, 1941, pp. 579.

[13]Hench, P. S., Bauer, Walter, Fletcher, A. A., Ghrist, David, Hall, Francis, and White, T. P.: The Present Status of the Problem of "Rheumatism" and Arthritis; Review of the American and English Literature for 1934, Ann. Int. Med. **9**:883-982 (Jan.) 1936.

[14]Codman, E. A.: The Shoulder; Rupture of the Supraspinatus Tendon and Other Lesions in or About the Subacromial Bursa, Boston, Thomas Todd Company, 1934, pp. 513.



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Protection of the Liver From Toxic Damage

Conducted by the Staff of the Pharmacology Department, Wayne University

The liver can now be accorded a measure of preferential treatment and consideration which would not have been possible a few years ago. The liver has been shown to play such a protean rôle in man's metabolism that dietary and other therapeutic efforts directed toward preventing damage to that organ are well justified. So much progress along this line has been made in recent years that a brief review of the pertinent data should be useful.

The toxicologist and internist could well use specific protective measures for the liver after exposure to such classical hepatotoxins as phosphorus, widely used in the present war; the arsenicals, used not only for syphilis but for certain parasitic diseases which the war will bring closer home, and the halogenated hydrocarbons whose increasing use in industry is leading to exposures that present a problem to the industrial physician.

The surgeon and anesthetist both have a vital interest in this problem. Morrison has shown that cyclopropane, nitrous oxide and spinal anesthesia do not produce any detectable postoperative damage to the liver. Chloroform, ether and rectally administered avertin cause brief and apparently reversible but nonetheless demonstrable postoperative damage.

The work of Ravdin and his associates has shown that the patient with chronic biliary disease can be made a better surgical risk when properly prepared by diet for operation. The choice of anesthetic in such a patient should be made with care in view of Morrison's work.

Saikowsky in 1865 showed that a damaged liver rapidly lost its glycogen. Apparently, little or no use was made of that finding until 1903 when Rosenfeld suggested that a high carbohydrate intake might be of value in preventing hepatic damage after chloroform anesthesia. Beddard, in 1908, first suggested the use of glucose in hepatic disease.

In 1914 Opie and Alford in this country first presented the case for carbohydrates to prevent hepatic damage in a sufficiently convincing manner to arouse general interest. Their work was well confirmed by Davis, Hall and Whipple, Graham and others. Since their work we have recognized that carbohydrate in adequate amounts will increase the glycogen content of the liver and that, in turn, will increase the resistance of the liver to hepatotoxins.

Ravdin and his associates have recently emphasized that carbohydrates will adequately perform this function only when given in amounts in excess of the basal caloric requirement. An occasional liter of 5 per cent glucose intravenously is not going to perform any miracles if the patient is on a submaintenance diet with a low total caloric intake. Tube feedings may be required and should more often be resorted to so as to assure a total daily intake of 3000 calories.

It has finally been made clear that hepatic regeneration depends on the protein in the diet. Bollman reported that, of the three major classes of foods, carbohydrates gave the greatest

and fats the least, protection to the liver against damage. Once damage had occurred, on the other hand, protein caused the most marked regenerative changes. Interestingly enough, the most valuable proteins thus far found for this purpose had been reported by Schultz and Vars to be those of liver itself.

The vitamins also are a definite factor in the integrity of the liver. The B complex is apparently the most important for Gyorgy and Goldblatt have shown that in its absence hepatic damage can be produced. The precise factors of the B complex responsible are not yet known although it is known that yeast will prevent the damage which vitamins B_1, B_2 and B_6 given alone cannot prevent.

Post and Patek, and Fleming and Snell have obtained marked improvement in hepatic cirrhosis by adding to otherwise adequate diets, approximating 75 per cent carbohydrate, 20 per cent protein and 5 per cent fat, large amounts of vitamin B in the form of brewer's yeast. Fifty grams a day should be given since homeopathic doses accomplish nothing. Lillie and his co-workers, investigating experimentally produced cirrhosis in rats, found that in the presence of an adequate diet a change of fluid intake from water to 20 per cent alcohol would not lead to cirrhosis.

The proof is mounting that alcohol, per se, has nothing to do with the development of hepatic cirrhosis. Adequate amounts of vitamin C have been shown necessary for proper wound healing. It is not too surprising, therefore, that Beyer has reported that guinea pigs on a diet supplemented with vitamin C are resistant to hydrazine-induced cirrhosis.

Let us summarize our present knowledge of treating hepatic disease or of preventing its development by dietary measures.

1. The caloric intake must be adequate and in the case of patients being prepared for surgery should be of the order of 3000 Cal. per day. About 75 per cent of that should be carbohydrate, about 20 per cent protein and the other 5 per cent fat.

Liver is the best source of protein and animal proteins, in general, are better than vegetable proteins. Tube feedings should be employed where an adequate intake cannot otherwise be achieved.

2. Supplementary amounts of the vitamin B complex to the extent of from 1 to 2 ounces of brewer's yeast per day and of vitamin C to the extent of 100 mgs. per day in divided doses should be given the patient.

3. Adequate iron should be given to combat any anemia present and in an anemia attended by severe hepatic damage adequate liver extracts should be freely injected, once the physician has assured himself the patient does not have pernicious anemia. That latter point is important for in pernicious anemia the liver must be taken throughout the patient's life, whereas, in treating the other anemia, it may be stopped once the blood picture has been restored to normal.

The patient with hepatic disease or the patient who is being prepared for surgery who does not receive this minimum diet as outlined is losing the aid of a potent force for his ultimate recovery.

Recently, new light has been shed on the treatment of acute hepatic poisoning caused by carbon tetrachloride. This treatment may well be applicable to other forms of acute hepatic poisoning. Miller and Whipple reported that dogs on a deficient diet sustained fatal hepatic damage after a half hour of chloroform anesthesia. This was prevented by the injection in one dose of a quarter of a gram of methionine per kilogram.

Beattie and his associates in England, mindful of this work, employed methionine in treating an aviator who

had ingested between 30 and 40 cc. of carbon tetrachloride. Since he did not vomit until forty-five minutes after ingesting it and since he showed unmistakable evidences of toxicity, including a rapidly enlarging liver, their assumption that he must have absorbed most, if not all, of the dose is reasonable.

The aviator was treated with a total of 9½ gms. of methionine given by injection and 6 gms. given orally over a period of four days. In addition, he received by infusion a papain-trypain digest of casein which gave him about 14.5 gms. total of dried material. This was given him on the assumption that other amino-acids might be of value.

Within four days a liver which had enlarged in the midline down to the umbilicus had receded to the point where it was barely palpable on deep inspiration. Within eleven days the patient had been restored to active duty apparently none the worse for the experience.

One such case proves little but if this work should be extended by many such cases as dramatically and successfully treated as was this one, then we shall be able to add methionine to our therapeutic armamentarium as a most important weapon to be used against acute hepatic poisoning.—Bradford N. Craver.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Uses of the Bronchoscope

Originally devised for the removal of foreign bodies in the air passages, the bronchoscope has achieved its greatest usefulness in the diagnosis and treatment of diseases of the respiratory system. Today, approximately 98 per cent of patients seen in bronchoscopic clinics represent cases of disease, whereas only 2 per cent require removal of foreign bodies.

In his article "Uses of the Bronchoscope," published in the October 1943 number of the "Bulletin of the School of Medicine of the University of Maryland," A. H. Dann classifies the uses of the bronchoscope as (1) diagnostic and (2) therapeutic.

Diagnostic bronchoscopy is indicated in the presence of signs and symptoms relating to the trachea, bronchi and lungs which are not accounted for by specific and accurate diagnoses.

The procedure serves to (a) note conditions that may be remedied by the bronchoscopic speculum, (b) reveal conditions that require irradiation or physical therapy, (c) reveal lesions that may require external surgery and (d) rule out the presence of disease.

The author enumerates and discusses 21 specific indications that include foreign bodies, neoplasms, infectious diseases, anomalies, postoperative complications and pulmonary disease in general. He emphasizes the fact that the greatest field for bronchoscopy lies in the diagnosis and treatment of pulmonary diseases.

The instrument is valuable as an aid in the establishment of a definite diagnosis, the etiology and the presence of pathological changes. It serves to localize lesions and to rule out lesions. By its use tissue may be obtained for biopsy and material obtained for smear and culture. It also aids in pneumography and in the removal of foreign bodies with the aid of the fluoroscope.

The uses of the bronchoscope in the treatment of disease are classified in four categories: (a) the removal of obstructing tissue, (b) the aspiration of tenacious secretions, (c) the dilatation of strictures and (d) the removal of obstructing secretions. Aspiration is of special importance in restoring the defensive mechanism of the lung and thus serves as a prophylaxis against pulmonary diseases. The writer lists 14 specific

indications for therapeutic bronchoscopy.

There are no contraindications to bronchoscopy if the need is urgent. In general, it should be performed only when indicated. It is inadvisable in serious organic conditions of the heart, in certain diseases of the blood vessels, hemoptysis and acute respiratory infections.

In conclusion, it is noted that the bronchoscope is of value in relation to other fields. Bronchoscopy has made it possible for the thoracic surgeon, the internist and the pediatrician to act as a team and has advanced their fields from both the standpoint of interpretation of signs and symptoms and in making possible accurate diagnoses. It has aided the study of such diseases as bronchial asthma. In the field of research, bronchoscopy has facilitated studies in bronchial and pulmonary physiology and pathology and has been responsible for the development of new advances in the diagnosis and treatment of medical and surgical intrathoracic diseases.—Edward Kirsch, M.D.

Primary Atypical Pneumonia

The account of primary atypical pneumonia, presented by Drew, Samuel and Ball in the *Lancet* for June 19, 1943, is based on a survey of the literature and on 50 cases personally observed in service patients between 1941 and 1943. This disease is characterized by gradual onset, few physical signs, varying radiological signs and, what is most important, it usually runs a benign course. It is not caused by any known bacteria. It is not a new disease, since it has been vaguely described since 1861 as soldiers' pneumonia and intestinal pneumonia. There seems to be a seasonal factor, most cases starting in March and April. Communicability seems to be low although transmission occurs via droplet infection.

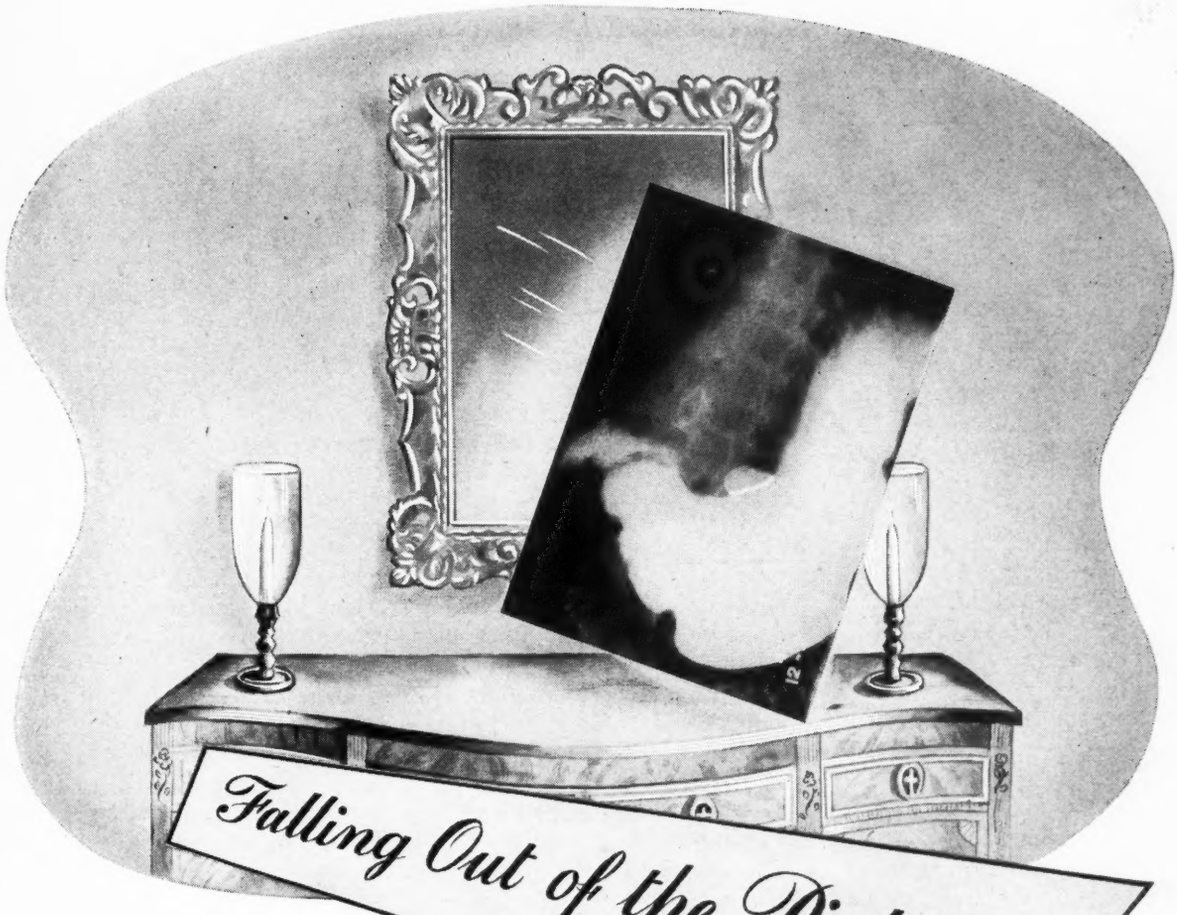
The disease is probably commoner than is generally recognized, since at the present time a definite diagnosis can be made only by x-ray examination. It is often confused with influenza, pulmonary tuberculosis and bacterial pneumonia because of similar radiographic and clinical pictures.

Onset is gradual and influenza-like. Symptoms are characterized by persistent productive cough, headaches and chest pains. Physical signs are scanty and fever ranges between 100° and 102° F. with subsidence in from seven to ten days. The course is usually simple, is rarely fatal and, in this series, the average hospital stay was thirty-three days. Recovery is usually complete.

No drugs are known to have any influence on the course of the disease nor is there any specific treatment. The sulfa drugs have apparently no effect. Treatment is bed confinement and symptomatic medication. Patient isolation was not used in this series and only one possible contact infection was noted—a nurse.

In an editorial on this subject in the same number of the *Lancet*, it is pointed out that the signs, symptoms and varying clinical picture of atypical pneumonia have been repeatedly described during the last ten years. It is noteworthy that the clinical picture is usually ill-defined and frequently confusing and contradictory. The editorial stresses the fact that the etiology is not definitely known and quotes from the significant work of Turner et al. in the same number of the *Lancet* (making the third contribution on this subject).

The editorial states that many signs point to a virus origin for this disease. These are (1) no bacteria have been demonstrated so far, (2) the lack of response to sulfonamide therapy which suggests virus etiology and (3) the established fact that in the United States a percentage of these cases is demonstrably caused by the psittacosis virus. The editorial concludes that atypical pneumonia is a virus disease with a multiple etiology. It is a syndrome and not a clinical entity.—Alexander W. Kruger, M.D.



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Cafeteria Helps Keep Them Happy

Good food in attractive surroundings boosts morale at Presbyterian Hospital

MILDRED WHITCOMB

A PROMISING experiment in personnel relations is going forward at Presbyterian Hospital, Chicago, in the guise of a staff and employes' cafeteria. Because of the happy results already achieved, a brief description of the project seems to be in order.

Several important groups registered a simultaneous lift in morale when last November a remodeling project was completed and the doors of a spacious, attractive, well-equipped and centrally located cafeteria swung open.

Let's start with the attending staff. These doctors left the indifferent food and deteriorating service of a near-by drugstore and claimed tables in the cafeteria where they can talk endless shop in cheeful surroundings. Their gain was real but the interns' profit was tremendous, for attending staff and house staff now draw up chairs to the same bleached oak tables and over a nutritious lunch informal man-to-man medical discussion vitalizes the planned post-graduate curriculum.

Take the patients' visitors next. The guest tray service open to them was, with the growing help shortage, somewhat reluctantly bestowed. Now, without leaving the building, visitors are welcomed to an excellent meal at a reasonable price.

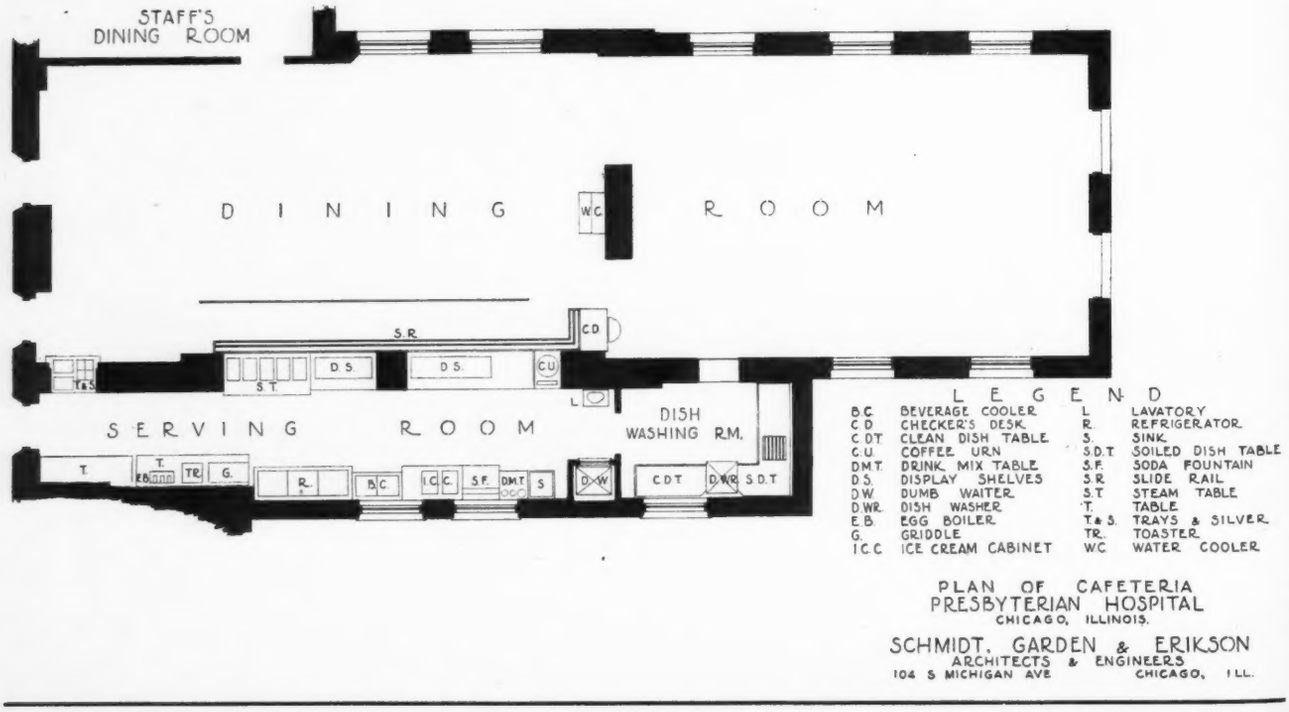
Too, the persons waiting about in examining rooms for delayed doctors once had nothing to distract their attention. Now with a snack or a "coke" close at hand they forget they are being inconvenienced.

The volunteers are a fourth group that praises the cafeteria service and to them the hospital grants free meals on the days they serve.

Finally, we come to the big group of employes who formerly ate a fixed meal in the hospital as a part of their compensation. If they did not happen to like the main dish, they were unhappy; if they didn't care for gelatin desserts they were disgruntled on the inevitable gelatin days. Without free choice of either eating place or menu they were inclined to envy their friends who had noninstitutional jobs.

In putting the central cafeteria plan into effect the hospital management took a long step forward. It gave employes their choice of eating one meal a day in the hospital or of having their salaries adjusted so that a meal similarly priced could be obtained on the outside.

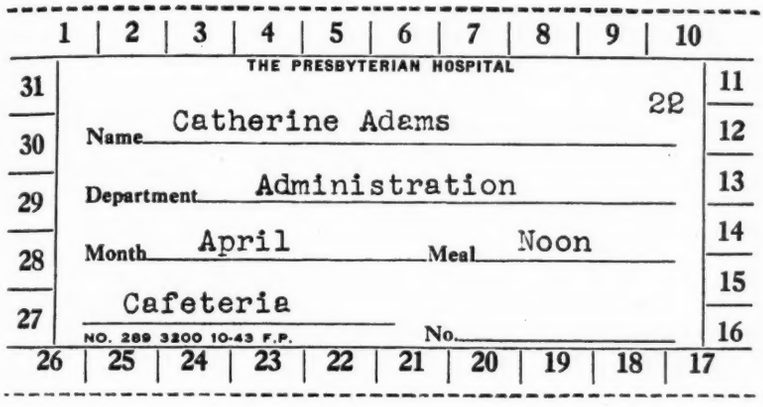
Most of them looked the situation over, found that the old fixed menu for everyone no longer held and signed up for meal ticket status. Others, not to be caught buying a pig in a poke, asked for the adjusted compensation. It pleases Beulah Hunzicker, chief of dietetics, as well



PLAN OF CAFETERIA
PRESBYTERIAN HOSPITAL
CHICAGO, ILLINOIS.

SCHMIDT, GARDEN & ERIKSON
ARCHITECTS & ENGINEERS
104 S MICHIGAN AVE CHICAGO, ILL.

Above, left: Plate mirrors above the wainscot convert a wall that could not be removed into a decorative asset. Above, right: Serving and dishwashing rooms behind the steam table are the new construction.



Sample of the meal tickets used by employes.

as Supt. Herman Hensel, to note that more and more the employes who don't have meal tickets are spending their adjusted salary allotments right there in the hospital cafeteria where the food is better, self-service is quick and they can joke and argue and gossip with their friends.

The cafeteria operates almost around the clock and this with its central location on the main floor adds to its popularity with the personnel. With a minimum of new construction, with something old and something new in equipment, without new personnel except for a cafeteria manager, the lunchroom opened under war-time conditions only after careful planning on the part of board, administrator, dietetics chief and architects.

The architects have utilized the available floor space judiciously. Food is sent from the main kitchen directly below by means of dumbwaiters, its delivery simplified by a two-way communication system. The arrangement of the cafeteria counter and work space is shown on the floor plan on page 102.

The serving room and dishwashing area represent new construction but the dining room itself, with its many windows, represents a partial union of two rooms formerly used for other purposes. The old partition could not be entirely eliminated as the ventilating shaft from the main kitchen occupied the center of the wall.

A 7 foot remnant of the former wall thus partially breaks the 80 foot room into two sections. This necessary compromise has been maneuvered into a decorative and utilitarian asset. Above the wainscot level the wall is covered on either side with plate mirrors. Against the partition stands the water station.

The walls are tinted off-white as are the indirect lighting fixtures. Color is to be added by great Audubon prints centered in the wall space between each pair of the many windows that light the room on three sides. Control of natural lighting is by venetian blinds, painted off-white. The floor is covered with brown marbelized linoleum; the ceiling is acoustically treated.

Adjacent to the lunchroom is a staff dining room where once a week or so 16 members of medical staff committees can be accommodated. The help situation being what it is today, waitress service is not always available for this private dining room so the doctors sometimes push their own trays down the cafeteria line just as they do on regular days when they eat in the cafeteria proper.

To operate a cafeteria almost around the clock requires three straight eight hour shifts. The morning crew reports at 6 a.m. for a 6:30 opening. Breakfast is served from 6:30 to 9 o'clock.

From 9 until 11 o'clock is the morning snack hour, orders being restricted to toast, prepared cereals, rolls, coffee, coca cola and ice cream. The usual patronage is 30 persons or so. The doors swing shut at 11 a.m. to give the cafeteria employes a chance to clean up and get the foods on the counter for the lunch hour onrush which starts at 11:30. Lunch is over at 2 p.m. and the afternoon snack period opens to continue until 4 o'clock when the doors close for half an hour's predinner preparation. Some 50 persons report for the afternoon snack consisting of ice cream, coffee or "cokes." The regular dinner service lasts from 4:30 to 7 p.m.

Promptly at 7 o'clock the employes start preparations for a 10:30 serving at night, which corresponds to the noon meal for the nurses and orderlies on afternoon and evening duty. This meal is served until midnight. After the midnight clean-up program, service is again resumed at

12:30 and lasts until 2 a.m. with student nurses and interns on night duty dropping in for sandwiches and coffee. The cafeteria workers then wash those dishes and clean up and when the clock strikes 3 a.m. they set out for home and the great room stands dark and silent for the stretch between 3 and 6 a.m.

To staff this twenty-one hour program only 10 employes and the cafeteria manager are required. The women employes like the congenial atmosphere and the turnover is slight in comparison to present day conditions. In fact, the congenial atmosphere is partly induced by these very women; Irish Nora and Winnie ladle out some of their quick wit with the soup or ice cream and employes arrive at their tables (which seat four or six) with two sure-fire aids to digestion: a happy frame of mind and a scientifically balanced lunch.

A bulletin board confronts the patron as he enters, carrying the day's luncheon or dinner menu which includes several choices, à la carte items and prices.

Breakfast is one meal that is entirely on a cash basis and the average check is from 25 to 30 cents. (Interns, of course, pay for no meals.) A number of employes rush in for a hot breakfast in the hospital before reporting on duty.

While the employe can get a lunch for 35 cents on his meal ticket, if he does not relish the menu he may order à la carte, paying cash for anything in excess of the 35 cents allowed for the meal. When a cup of delicious soup is only a nickel; a sandwich, 15 or 20 cents; a salad, 5 or 10 cents; coffee, 5 cents, and dessert, 10 cents, employes rarely need to exceed their allotment.

One labor and equipment saving discovery was made early in the operation of the cafeteria. By removing the soup spoons from the silver rack at the beginning of the counter and placing them adjacent to the soup section of the steam table, no customer takes a soup spoon unless he means to use it. This counts in the dishwashing as well as in silverware replacement. No bus boys are available and cafeteria patrons cheerfully carry their own soiled dishes to the proper window. Visitors note the custom and imitate it.

For the 850 to 900 meals served daily, a cost accounting system is being worked out at the present time.

—Geriatrics Series—

FOOD for the AGED

EDUCATION is an important factor in dietetics as it applies to geriatrics. One of the big challenges to the dietitian is to encourage old people to eat proper foods and to show them how through correct diet they can enjoy better health and increased vitality.

Respond to Right Approach

Speaking on this subject, the dietitian of a large institution says: "In carrying on such a program we are aided by having those people whom we are trying to guide and help under the same roof with us for periods of months and years. This provides an opportunity not only to serve them adequate well-balanced meals but to supervise what they eat and to guide them to better food habits. This is not always easy because habits acquired in youth grow more confirmed with advancing years. Nevertheless, it is surprising how they will respond when properly approached.

"The responsibility for seeing that old people get adequate meals rests with the individual who plans the menus and with those who prepare the food. In planning the dietary of our aged residents we strive to follow the nutrition standards established by the National Research Council.

"The council's standards include in the daily diet (1) one pint or more of milk for vitamin A, high quality protein and adequate calcium; (2) tomatoes, oranges, grapefruit or their juices for vitamin C; (3) a serving of green or leafy vegetables, occasionally yellow for vitamins A, B_1, G, some C and for minerals; (4) eggs, at least four or five weekly, lean meat or fish for protein, vitamins of the B complex and iron; (5) potatoes at least once daily for vitamins B_1, C and for iron; (6) whole grain cereal and whole grain or enriched bread for vitamins of the B complex and for iron; (7) fruit, fresh and dried, one or two servings daily, for minerals and vitamins.

"If these basic foods are included in the daily diet and the food is cooked properly so that the minimum amount of vitamins and minerals is lost we may be assured that the diet possesses the essential elements. The caloric requirement of the aged tends to decrease owing both to lowered basal metabolism and to their limited activity and exercise. We serve them about 2000 calories per day which is adequate for individuals in this age group.

Some Precautions to Take.

"What calories are required should be supplied, with careful consideration to the slowing up of body functions. Because of lack of exercise, there is always danger of constipation. For this reason the dietitian should include roughage in the form of adequate amounts of fruits and vegetables, as well as proper quantities of fluid which are included to forestall any tendencies toward sluggish digestive tracts.

"Frequently, elderly people are either completely edentulous or have many teeth missing. They must be provided with soft, easily mashable food. Chopped meat variations, such

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REMINDER TO DIETITIANS

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as hamburger, Texas hash and corned beef hash, are popular.

"It is advisable to plan the meals of these old folk so that the heaviest comes at noon followed by a light supper. Too large quantities of food, also heavy food taken at night, may contribute to gastro-intestinal distress. It has been our experience that hot suppers are more palatable than cold plates but that salads are welcome if served with a baked potato or corn pudding. Hot cereal with milk or a creamed soup is provided as an alternative at suppertime for those who for one reason or another cannot eat the regular supper.

"Simple dishes, well seasoned although not spicy, should form the basis for the menu planning. Old people do not respond to new and tricky recipes. Consequently, the dietitian will spare herself much useless effort and disappointment if she adheres to the familiar 'tried-and-true' dishes.

"Similarly, it would be well to stay away from the less common vegetables, such as broccoli, and stick to the old reliables—peas, beans and carrots. Another reason, too, for using sparingly such vegetables as cabbage, turnips, broccoli and cauliflower is that they are gas forming.

"Old people are likely to have a sweet-tooth. In this preference they are much like children. Like children, too, they invariably prefer the simpler desserts, ice creams, plain puddings, stewed or canned fruit and cake.

"Following is a typical menu based on the nutritional requirements previously described. *Breakfast:* fruit juice, cereal or eggs, two slices of bread or rolls, coffee or milk; *dinner:* soup, roast veal, mashed potatoes, string beans, bread, stewed pears, coffee, tea or milk; *supper:* scrambled eggs, chopped lettuce and tomato salad, chocolate pudding, bread and butter and coffee, tea or milk.

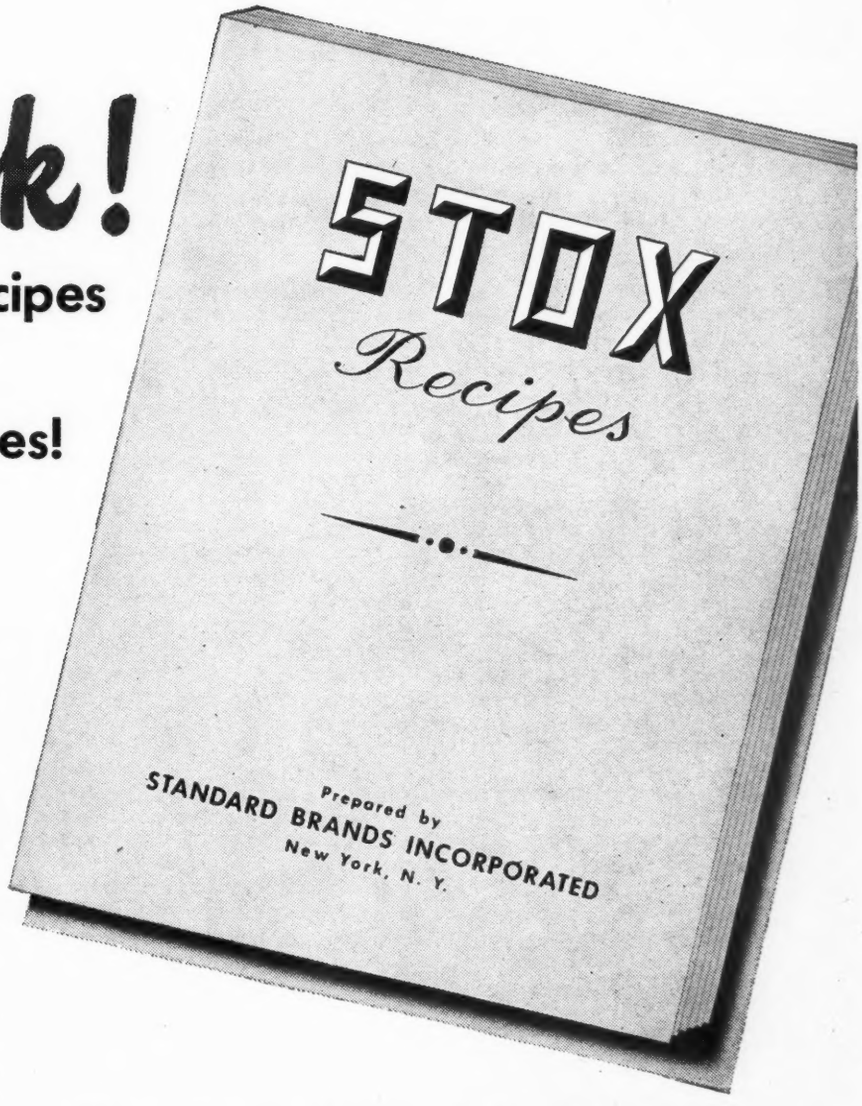
"Although special diets do not present the same problems as in a general hospital there are always diabetics and others suffering from intestinal disturbances. We have found that it causes less unhappiness to serve everyone the same basic menu in the dining room and provide the necessary substitutions. The diabetic will find an extra vegetable on his dinner plate instead of a potato, when the regular supper includes a potato or potato substitute, and fruits will be unsweetened. Those who are suffering from stomach ulcers get additional milk and cream and soft cooked eggs.

"The manpower situation in an institution for the aged is helped to some extent by residents who will share some of the burden. The women actually enjoy such simple tasks as keeping the salt and pepper shakers and sugar bowls filled and cleaned. In the kitchen, too, they are helpful in vegetable preparation. In fact, the availability of such labor makes it possible to serve fresh vegetables which otherwise would be impractical.

"Once the general dietary pattern is set with good food, well prepared and attractively presented, the problems in catering to the aged parallel to large extent those found in any other type of food service. The greatest challenge lies in educating these old people to the importance of proper diet, in proving to them that they can enjoy the foods that are put before them and at the same time enjoy the benefits of good nutritional habits."

Free Book!

65 Tested Recipes for Delicious Wartime Dishes!



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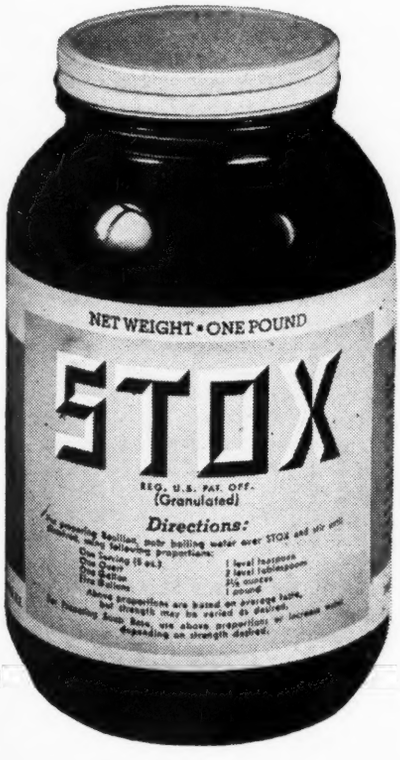

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Check That Dishwasher

NO MACHINE can take care of itself. This timely reminder comes from an authority on the subject of dishwasher maintenance. Despite the manpower situation he urges, if at all possible, a thorough cleaning and inspection once a week to assure long life for the equipment.

Dirt is likely to accumulate in small openings and on the less accessible inside surfaces. The problem is to know which parts of the machine are easily disassembled to facilitate proper cleaning.

"Spray openings vary in area from .012 to .070 square inch," our informant continues. "The small ones clog more easily than do the large openings. Stiff brushes work well for cleaning nozzles and tubes, but occasionally bristles break off and cause clogging in the manifold. This can be avoided by using a knife to push food particles from the spray tube slots into the tubes. Tubes can be cleared by flushing with water or blowing out with steam.

"Dirt that interferes with dishwashing machine production is chiefly grease, but deposits of lime, alkali and calcium adhere more tenaciously and can do more lasting damage. Grease layers thicken quickly, imprison decaying food particles and are friendly to germs, but grease is the type of dishwashing machine dirt that can be gotten rid of.

"Strong cleaning solutions should be used cautiously, if at all. Lye is popular for cleaning greasy machines, but it is corrosive and its cleansing action is deceptive: it may merely cut a channel through the grease without removing all of it, and it does not remove scale deposits. Diluted muriatic acid can do a more effective job but requires expert handling.

"There are detergents on the market that will effect removal of reasonable dirt accumulations safely. In the case of old machines, however, it may be advisable to employ more specialized services, available through manufacturers, to restore them to condition for a clean start.

"Weekly inspection combines naturally with the cleaning job. Examine openings in the regulators or automatic feeders. Watch for worn washers. Defective spray washers cause loss of pressure. Defective valve washers may necessitate replacement or reseating of the valves. Using the wrong wrenches on valves rounds them off or wears them out.

"Worn or broken parts should be repaired or replaced. Jagged edges on racks or metal parts are especially bad, as they catch and hold dirt particles, cause dish breakage and frequently injure the operators.

"Make sure the pump is always well packed. To obtain new packing of the right type, it is advisable to order it directly from the manufacturer of the machine.

"Proper lubrication is an elementary requisite for trouble-free service from any machine but it is often neglected. A few drops of oil should be put in the oil cups in the motor once a month and grease cups should be kept filled with a good grade of grease. But don't put grease in oil cups or oil in grease cups! Grease cups should be turned slightly every day so that grease will work down into the machinery."

Dear Boss:
It certainly is a "small" world

A few months ago we received a note from a Hobart man stationed overseas. He wrote it on a typical rookie's desk—a box. Before the letter was finished he saw to his delight—and ours!—that the empty box on which he wrote was stenciled with a name he knew quite well. The name was Hobart.

In a way, this soldier writing on an empty box has become a symbol to us . . . a symbol of the nearly one thousand Hobart men who now wear the uniforms of six Allied nations . . . a symbol of the thousands of products made by Hobart that are used on the fighting fronts. These men and these products are helping to set this "small" world free.

Six Allies—with more than one thing in common

Today, former Hobart men are serving in the Armed Forces of the United States, Great Britain, Canada, Australia, Brazil, and Free France. In addition to the common cause for which they fight, these men were pre-war compatriots of the world-wide Hobart organization.

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Menus for June 1944

Gladys M. Sylvester
Winthrop Community Hospital
Winthrop, Mass.

Recipes will be supplied by The MODERN HOSPITAL, Chicago.

1
Fresh Rhubarb
Boiled Eggs

•

Barley Broth
Roast Lamb, Mint Sauce
Browned Potatoes
Wax Beans
Buttered Carrots
Chocolate Pudding

•

Cream of Celery Soup
Chicken Salad
Baked Potatoes
Peaches
Cake

2
Half Oranges
Scrambled Eggs

•

Clam Bouillon
Broiled Mackerel,
Lemon Sauce
Mashed Potatoes
Swiss Chard
New Beets
Strawberry Shortcake

•

Cream of Mushroom Soup
Tomato, Stuffed Egg
Salad
Potato Chips
Prune Plums
Walnut Cake

3
Prunes
Soft Cooked Eggs

•

Chicken Soup With Rice
Baked Ham, Raisin
Sauce
Parslied Potatoes
Beet Greens
String Beans
Coffee Whip With
Custard Sauce

•

Tomato Juice
Tuna à la King
Toast Points
Pears, Cheese, Pimiento
Salad
Ribbon Gelatin
Sponge Cake

4
Grapefruit
Poached Eggs

•

Fruit Juice Cocktail
Fricassee of Chicken
Mashed Potatoes
Fresh Asparagus
Summer Squash
Grapenut Ice Cream
Cookies

•

Corn Chowder, Crackers
Fruit Salad
Caramel Custard
Fluffy Cake

5
Applesauce
Jelly Omelet

•

Mixed Pickles
Pot Roast of Beef
Boiled Potatoes
Green Peas
Creamed Corn
Banana Custard

•

Spaghetti and Tomato
in Casserole
Stuffed Celery Salad
Peaches
Fruit Cake

6
Tomato Juice
Bacon

•

Alphabet Soup
Baked Haddock,
Parsley Sauce
Escalloped Potatoes
Dandelion Greens
Wax Beans
Fresh Strawberry Gelatin

•

Cream of Pea Soup
Salmon and Celery Salad
Potato Sticks
Applesauce
Brownies

7
Bananas
Shirred Eggs

•

Fruit Punch
Chicken Pie
Mashed Potatoes
Glazed Carrots
Cauliflower
Vanilla Ice Cream,
Chocolate Sauce

•

Tomato Bisque
Ham Omelet
Hashed Brown Potatoes
Fresh Pineapple
White Cake

8
Sliced Oranges
French Toast

•

Chicken Soup
Hamburg Loaf,
Mushroom Sauce
Fluffy Rice
Swiss Chard
Savory Beets
Butterscotch Meringue Pie

•

Beef Croquettes, Cream
Sauce
Green Peas
Shredded Lettuce,
Russian Dressing
Strawberries and Cream
Fudge Cake

9
Figs
Boiled Eggs

•

Vegetable Soup
Broiled White Fish
Mashed Potatoes
Escalloped Tomatoes
and Corn
New Zealand Spinach
Pineapple Delight

•

Creamed Codfish
Baked Potatoes
Garden Salad
Fruit Cup
Spice Cake

10
Grapefruit Juice
Scrambled Eggs

•

Beef Stew
Boiled Potatoes
Buttered Carrots
Green Peas
Dill Pickles
Cottage Pudding, Vanilla
Sauce

•

Welsh Rabbit on
Crackers
Bacon Curls
Tomato Salad
Canned Pears
Hermits

11
Rhubarb Sauce
Fish Cakes

•

Gingerale-Grape Juice
Punch
Roast Chicken, Quince
Jelly
New Potatoes
Fresh Asparagus
Hubbard Squash
Peanut Brittle Ice Cream
Cookies

•

Cream of Corn Soup
Combination Salad
Potato Chips
Banana Gelatin
Cake

12
Orange Halves
Poached Eggs

•

Noodle Soup
Corned Beef
Parslied Potatoes
New Beets
Carrot Sticks
Mustard Pickles
Strawberry Whip

•

V-8 Cocktail
Jellied Ox Tongue
Creamed Potatoes
Coleslaw
Peaches
Ginger Cookies

13
Prunes
Bacon and Eggs

•

Beef Broth
Fillet of Sole,
Tartare Sauce
Au Gratin Potatoes
Succotash
Beet Greens
Rhubarb Pie

•

Meat and Vegetable
Casserole
Lettuce, Chili French
Dressing
Loganberries
Spice Cake

14
Tomato Juice
Scrambled Eggs

•

Orange Punch
Baked Chicken
Mashed Potatoes
Wax Beans
Fresh Asparagus
Caramel Ice Cream
Cookies

•

Goldenrod Toast
Waldorf Salad
Raspberry Bavarian Cream
Cake

15
Rhubarb
French Toast

•

Chicken Bouillon
Liver and Bacon
Duchess Potatoes
Cauliflower, Hollandaise
Sauce
Green Peas
Dill Pickles
Fruit Gelatin With Cream

•

Tomato Soup
Macaroni and Cheese
Tossed Green Salad
Watermelon
Mocha Cake

16
Sliced Oranges
Omelet

•

Baked Mackerel, Sliced
Lemon
Riced Potatoes
Spinach
Stewed Tomatoes
Radishes
Strawberry Shortcake

•

Cream of Mushroom Soup
Tunafish Salad
Baked Potatoes
Pineapple
Toll House Cookies

17
Sliced Bananas
Poached Eggs

•

Soup du Jour
Hamburg Patties,
Spanish Sauce
Parslied Potatoes
Creamed Celery
String Beans
Apple Betty, Nutmeg
Sauce

•

Chicken-Fresh Vegetable
Soup
Crackers
Tomato and Sliced Egg
Salad
Applesauce

18
Grapefruit
Fish Cakes

•

Boiled Fowl, Cream Gravy
Mashed Potatoes
Baked Squash
Fresh Asparagus
Lemon Milk Sherbet
Cookies

•

Tomato Bouillon
Cheese Soufflé, Bacon
Shredded Lettuce,
Chiffonade Dressing
Prune Plums
Devil's Food Cake

19
Figs
Boiled Eggs

•

Vermicelli Soup
Baked Ham, Apple Rings
Franconia Potatoes
Parslied Carrots
Wax Beans
Rice Custard

•

Chicken à la King
Fluffy Rice
Perfection Salad
Rhubarb Sauce
Hot Milk Cake

20
Orange Slices
Poached Eggs

•

Chicken Broth With Rice
Baked Finnan Haddie
Mashed Potatoes
Beet Greens
Soy Beans
Fresh Strawberry Ice
Cream

•

Fish Chowder, Crackers
Tomato and Cottage
Cheese Salad
Peaches
Banana Cake

21
Tomato Juice
Scrambled Eggs

•

Grape Juice Punch
Fricassee of Chicken
Mashed Potatoes
Cauliflower au Gratin
Asparagus
Gingerbread, Sunshine
Sauce

•

Cream of Celery Soup
Escalloped Potatoes
and Ham
Garden Salad
Fruit Gelatin With Cream
Walnut Cake

22
Applesauce
French Toast

•

Roast Lamb, Grape Jelly
New Potatoes
Summer Squash
Green Peas
Radishes and Celery Sticks
Queen Pudding

•

American Chop Suey
Cabbage and Apple Salad
Fruit Cup
Chocolate Layer Cake

23
Rhubarb
Shirred Eggs

•

Tomato Bouillon
Baked Stuffed Haddock
Riced Potatoes
Swiss Chard
Savory Beets
Pineapple Upside-Down
Cake

•

Cream of Corn Soup
Salmon and Celery Salad
Latticed Potatoes
Strawberries and Cream
Mocha Cake

24
Figs
Boiled Eggs

•

Noodle Soup
Yankee Pot Roast
Parslied Potatoes
Carrots and Peas
Spiced Pears
Grapenuts Pudding

•

Tomato Rabbit
Toast Points
Stuffed Egg Salad
Boysenberries
Sugar Cookies

25
Half Oranges
Poached Eggs

•

Grapefruit Juice
Roast Duck
Mashed Potatoes
Asparagus, Hollandaise
Sauce
Cranberry Jelly
Maple Walnut Ice Cream
Cookies

•

Cream of Mushroom Soup
Assorted Sandwiches
Pear, Cheese, Ginger Salad
Jelly Roll

26
Prunes
Omelet

•

Beef Broth
Veal Loaf, Creole Sauce
Fluffy Rice
String Beans
Mashed Turnip
Mocha Pudding

•

Shepherd's Pie
Hearts of Lettuce,
Russian Dressing
Peaches
Spice Cake

27
Sliced Bananas
Bacon

•

Pea Soup
Broiled Whitefish
Delmonico Potatoes
Spinach
Escalloped Tomatoes
Strawberry Chiffon Pie

•

Curried Lamb on Rice
Coleslaw
Fresh Fruit Cup
Orange Cake

28
Grapefruit Juice
Scrambled Eggs

•

Beef Bouillon
Chicken Pie
Boiled Potatoes
Green Peas
Lima Beans
Peppermint Stick Ice
Cream
Cookies

•

Noodle Soup
Salmon Loaf
Lyonnaise Potatoes
Radishes and Celery
Chocolate Pudding

29
Orange Slices
French Toast

•

Alphabet Soup
Swiss Steak
Mashed Potatoes
Soy Beans
Summer Squash
Butterscotch Rice

•

Split Pea Soup
Scrambled Eggs and
Bacon
Tomato Salad
Green Gage Plums
Mocha Cake

30
Rhubarb Sauce
Boiled Eggs

•

Vegetable Soup
Baked Mackerel
Parslied Potatoes
Beet Greens
Wax Beans
Tomato Relish
Orange-Pineapple Gelatin
With Cream

•

Codfish Hash
Waldorf Salad
Pickled Beets
Boston Cream Pie

—and Kellogg's individual packages save hospital time and labor

WHEN you are serving Kellogg Cereals to patients and staff—you do them, and the hospital, a real favor. *First;* as delicious food Kellogg Cereals get a real welcome. In fact, they're so popular that more packages of Kellogg's are bought than those of *any other* cereal line. Kellogg Cereals are excellent food, too—they are either whole grain, or the equal of whole grain in nearly all the protective food elements declared essential for human nutrition. *Second*: They SAVE HOSPITAL TIME AND LABOR. There's no cooking and no pans to wash. Simply open the individual packages and serve. Sanitary, of course. So, isn't it wise all 'round to serve Kellogg's Cereals consistently?

Made by Kellogg's in Battle Creek, Michigan.

The Grains are Great Foods — W. K. Kellogg

ANOTHER GREAT TIME-SAVER BY

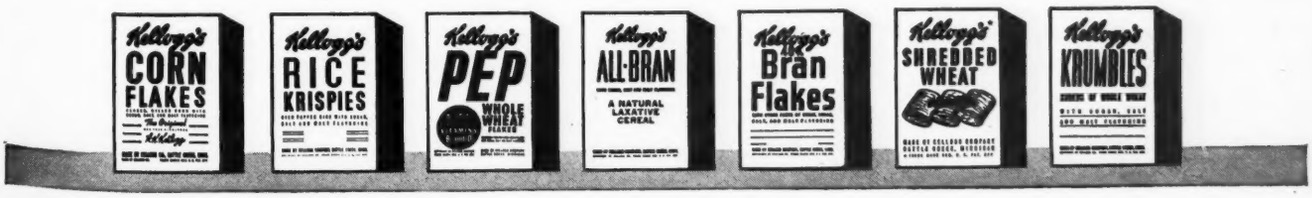
Kellogg

THE KEL-BOWL-PAC

1. OPEN THE PACKAGE

2. ADD CREAM AND FRUIT

3. EAT RIGHT OUT OF THE CARTON



A Hotel Shows the Way

to air conditioning of the future

CARL E. RIBLET JR.
Chicago

MODERN air conditioning is expected to reach into American hospitals after the war to bring greater comfort to the nation's sick and their nurses and doctors, according to a study by Holabird and Root, Chicago architects and engineers.

There is a perfect air-conditioning system in existence. It is a system that uses only fresh air and was designed and engineered by Holabird and Root for the new Statler Hotel in Washington, D. C. It may be studied by hospitals with profit.

Germs May Be Recirculated

The average air-conditioning system depends on only partial distribution of fresh air. If some of the persons using a room have cold infections, their coughs and sneezes carry the germs into the air-conditioning system and those germs are, or may be, recirculated throughout the system.

Under the new system of the Washington Statler, *all* the air is fresh. Following is a description of how the new pure air system works in this hotel.

The outside air for introduction into the guest room conditioning system is taken in at the fifteenth floor level, where the principal primary treating and handling apparatus is located. In the summer season the air is filtered and dehumidified and in winter it is filtered and humidified.

There are two main primary air treating devices from which the air is further subdivided into four zones, which permits adjustment of the temperatures in the main distribution system according to the building exposure. The main primary air fans are also located on the fifteenth floor, from which the air is conveyed through circular ducts to the guest rooms by means of vertical risers carried down around the outer wall, each riser serving a tier of rooms or, in some cases, two adjoining tiers of rooms.

Owing to the relatively high pressure and resultant high velocity at which the air is distributed in the conduit system, the circular ducts can be kept to a small size, in some cases not greatly larger than the covered steam pipes ordinarily used for heating.

It is this property of the conduit system that makes it especially adaptable to multistoried buildings, which, when conditioned by the conventional methods, usually require unwieldy duct sizes that seriously interfere with the treatment of the rooms and encroach upon otherwise usable floor space—all of which is ultimately reflected in increased building cubage and cost.

In each guest room a small-sized air pipe tap is taken off the vertical primary air riser and is extended in a room distribution unit located directly under the window.

This room unit contains a system of air supply nozzles and a small secondary coil. The primary air conveyed through the small pipe tap is delivered through the nozzles, again at a high velocity, emerging into the room through a grille in the top of the unit.

A second grille is placed in the front panel of the unit directly before the secondary coil and the injector effect of the primary air issuing at high speed from the nozzles induces a secondary flow of air through the front grille and the coil that mixes with the primary air before being delivered into the room.

There are no motors or moving mechanical parts in the guest room units so that there is no source of noise or vibration at this point. The units are baffled and soundproofed so that under ordinary conditions it is impossible to detect any sound whatever in connection with the air delivery.

The small secondary coil in the units circulates hot water in winter and chilled water in summer, the control of which permits adjustment of the temperature of the primary air as received from the main units according to the individual desires of the room occupants.

The temperature adjustment is accomplished by means of a so-called "thinking valve" which can be set by the occupant and, once set, will operate automatically to maintain the desired temperature, regardless of variations in the outside temperature, up to the capacity of the unit.

The room unit also contains a manually operated damper in the air supply pipe by means of which the entire unit can be turned off if the occupant of the room so desires.

All Air Comes From Outside

It can be seen that all of the air conveyed to the rooms through the duct system is outside air and the only recirculation effected is within the room itself. There are, therefore, no general recirculation and no interchange of air between rooms. This feature is especially important to hospitals.

An important advantage of the primary and secondary method of air treatment in this system lies in its extreme flexibility and ability to produce the many different degrees of temperature required to suit the varying tastes of individual guests or patients.

When the outside temperatures are on the borderline between heating and cooling seasons, it is possible

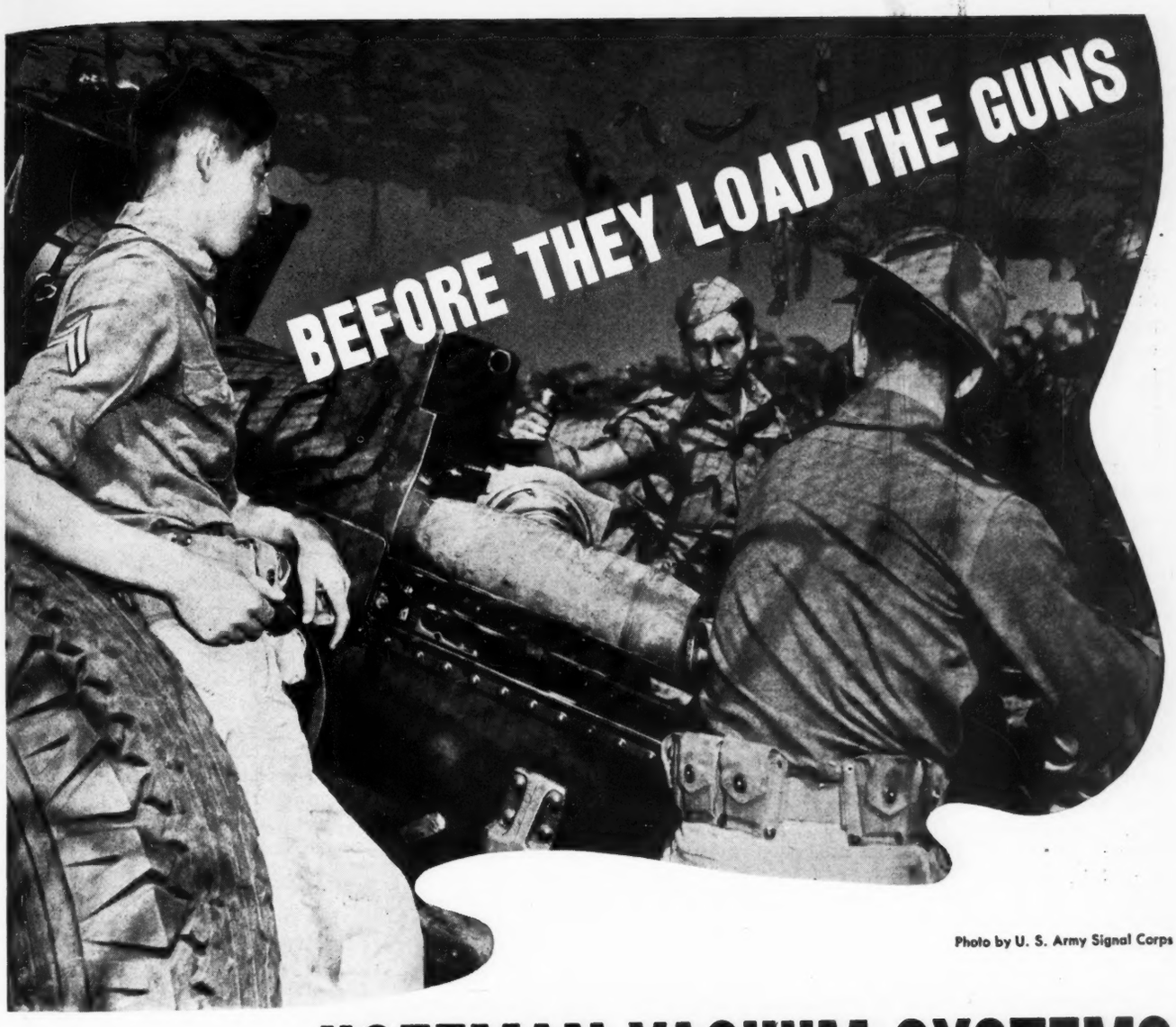
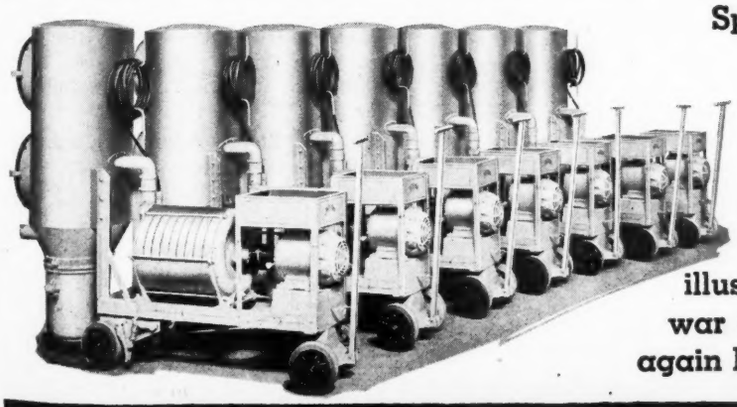


Photo by U. S. Army Signal Corps

HOFFMAN VACUUM SYSTEMS HELP LOAD THE SHELLS!



Special Hoffman Stationary Dust Control Systems are performing vital service on production operations in Army and Navy ammunition loading plants—handling dusts from military explosives. Separate Hoffman Vacuum Cleaning Units—like those illustrated—are also used in these important war industries. After Victory—Hoffman will again build fine Hospital Laundry Equipment.

U. S. HOFFMAN MACHINERY CORPORATION
107 Fourth Ave., New York 3, N.Y.

COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

to operate the system so as to heat one room and cool an adjoining room to the moderate degree required by the intermediate outside temperatures. This is accomplished by circulating warm air in the primary distribution system and chilled water in the secondary coil system, or vice versa.

For hospitals in cities and built-up communities, ventilation of patients' rooms, corridors and operating rooms is of prime importance and even a necessity. This would include air filtering and humidifying for winter use. Humidifying entails only a moderate cost when ventilating systems are provided, and while the improvements resultant therefrom cannot be positively evaluated, winter-time humidification is generally accepted as being highly desirable.

Whether comfort air conditioning eliminates or reduces epidemics of colds or other respiratory illnesses is not possible of accurate determination at the present stage of development.

ENGINEERS' QUESTION BOX

Testing Fluorescent Lights

Question 36: What is the best way of testing lamps, ballast coils and starting switches on our fluorescent lighting fixtures?—J.B., Me.

ANSWER: (*This is a continuation of Mr. Fischer's discussion in this column in the April issue.*—ED.)

The accompanying sketch of a portable test box that can be made up in the hospital's shop shows the circuit wired with two 40 watt lamps to check fluorescent units of from 15 to 40 watts, and two 100 watt 120 volt lamps used for checking 100 watt units.

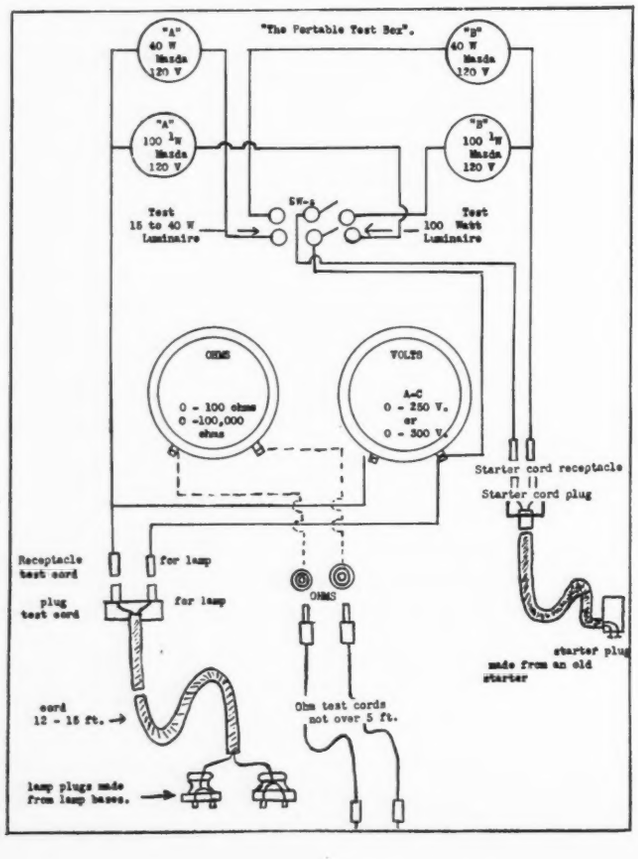
To check a luminaire: (1) remove all lamps and starters; (2) insert the starter plug in the starter socket; (3) insert lamp plugs in lamp holders; (4) with switch SW-S "open" read the open circuit voltage; (5) close switch SW-S and note the appearance of the two lamps in the test box. SW-S is to be closed to one side or the other, depending on size of luminaire tested.

Normal Lamp Operations:

1. Open circuit voltage, which is based on the ballast design voltage being applied to the luminaire, can vary a plus or minus 7½ per cent with plus or minus variations in the line voltage.

As at least a hint as to what to look for, the following table is offered:

118 volts for 15 watt lamps
118 volts for 20 watt lamps
200 volts for 30 watt lamps
200 volts for 40 watt lamps
150 volts for 100 watt lamps



2. It is normal in a circuit with low power factor for both lamps "A" and "B" to glow dim and lamps to appear to be of equal intensity.

3. It is normal in circuits with high power factor for lamp "A" to glow dim and lamp "B" to glow very dim.

Indications of Defects:

1. Zero Open-Circuit Voltage: Neither lamp glows.

Cause of Trouble: Lamp holders, wiring or ballast.

Remedy: Check lamp holder, connections for poor contact; check all wiring for open or poor connections; if no loose connections or "grounds" are found change the ballast. Note the test for grounds in the wiring and lamp holder connections. There is where the ohmmeter will prove a great help.

2. Open Circuit Voltage Correct: Lamp "A" glows bright; lamp "B" does not glow.

Cause of Trouble: Starting circuit open.

Remedy: Check starter and starter socket; check wiring for loose connections. Trouble found to be in lead lamp may be caused by an open circuit in the compensator. Short the compensator out and if the lamp "B" glows the compensator is defective and should be replaced.

3. Open Circuit Voltage Correct: Lamp "A" glows extremely dim; lamp "B" does not glow.

Cause of Trouble: Shorted lead reactor.

Remedy: Replace the ballast.

4. Open Circuit Voltage Correct: Both lamps "A" and "B" glow extremely bright.

Cause of Trouble: Shorted lag reactor.

Remedy: Replace ballast.

5. (This trouble will only be found in 30, 40 and 100 watt luminaires.) Open Circuit Voltage Low, approximately equal to the line voltage: Both lamps glow very dim, or lamp "A" is very dim and "B" shows no evidence of glow.

Cause of Trouble: Burned out autotransformer;

Remedy: Replace the ballast.

Another test cord can easily be made up by opening an old starter and soldering the two ends of an all-rubber No. 18 lamp cord to the starter pin contacts. The cord is made as long as will be convenient, and at the other end of the cord is attached a push switch or a cord through switch in such a way that the circuit is normally open and is closed when a starting test is to be made, then opened.

First, remove the starter and insert the test cord in its place; then the switch is closed for a few seconds and

opened again. If the lamp and ballast are good the lamp will light up. This tells one that the starter is at fault. If the lamp shows further trouble or fails to light at all, then one will have to look elsewhere for the trouble.—JAMES C. FISCHER, *chief engineer, Milwaukee County Institutions and Departments, Milwaukee.*

Stoker *vs.* Slack Coal

Question 49: What are the relative advantages of stoker coal, oil treated or not oil treated, to be used in a stoker instead of slack coal?—G.P.S., Ky.

ANSWER: The choice of coal depends on the type of stoker. Stoker coal, which is 1½ inches by No. 10 mesh or ¾ inch by No. 10 mesh is recommended for use in underfeed stokers only, as it is the best size for efficient operation. It would be quite a problem to burn slack coal in a stoker of this type.

Chain grate stokers could use the same sizes, though slack coal will burn efficiently as there is time enough to burn it.

The spreader type of stoker could possibly burn slack, though ¾ inch by No. 10 mesh or pea coal is better.

Stoker coals are more efficient because more complete combustion takes place owing to proper sizing; this means more Btu. release in the fire box. Stoker coals are lower in ash, sulphur and moisture and higher in fixed carbon and volatile matter, which means greater efficiency.

Your stoker installation should determine the type of coal used; the price delivered is also a factor, but the final answer should be determined from the cost per thousand pounds of steam generated. (This is a difficult question to answer properly.)—LELAND J. MAMER, *chief engineer, Evanston Hospital, Evanston, Ill.*

Best Soap for Dishwashing

Question 51: What kind of soap is best for use in an electric dishwasher? What is the hardness of your water?—O.F.K., Neb.

ANSWER: There are three soaps which I think are best for this purpose. One is an old reliable and the other two are comparatively new. One of these is in brick form and easier to handle than the other two, which are powders. All three have automatic dispensers and maintain water at the proper Ph value and hardness necessary to do the job. All three are of the metaphosphate type, which means that they will keep machines from scaling. At least that has been our experience and we use Lake Michigan water, which is 8 grains in hardness.—LELAND J. MAMER, *chief engineer, Evanston Hospital, Evanston, Ill.*

HOUSEKEEPING

Conducted by Alta M. LeBalle

Jobs for Volunteers

When a large and busy hospital rejoices in only one porter who can climb a ladder without fainting, who's going to do the high dusting? And in that same hospital, when one of the huskiest of the maintenance men suddenly gets an "inspiration" to walk out in the middle of the morning and join the Merchant Marine, thereby depleting an already depleted crew, who's going to pitch in and do his work?

At one midwestern hospital, which answers to the description of both large and busy, help in solving the manpower shortage has come from a group of alert, active citizens recruited from the men's clubs of the town who are glad to give a few hours each week doing such vital, if unglamorous, jobs as cleaning and refilling fire extinguishers, repairing overstuffed furniture, waxing table tops, oiling hinges and dusting.

The volunteers were assigned to housekeeping work because the department renders service until midnight under the direction of a night housekeeper. Hence, it fell to the lot of the housekeeping department to direct the energies of the volunteers into channels that would be of the greatest benefit to the hospital and would keep the patriotic helpers interested. Too, it was necessary to select jobs that could be done at night without disturbing patients.

In order to achieve these goals, the head of the housekeeping department listed the various types of work that volunteers could do successfully and then set up specific instructions for each job so that there would be as little

(Continued on Page 120)

GENERAL RULES

1. Please report to housekeeper's office. Miss Blank is night housekeeping supervisor. Your lockers will be assigned from here.
2. Always wear the identification band, marked "Volunteer."
3. Before starting on any given job, please check with the nursing divisional supervisor so as not to interfere with patient care.
4. Please report to the housekeeping office any parts that are too badly damaged for you to repair.
5. If at all possible, please bring your own tools.

TYPES OF JOBS

1. Clean and fill grease cups on (a) gatch beds; (b) bed casters and overbed tables.
2. Oil door hinges.
3. Replace rubber hushers, bumpers and door stop feet.
4. Change electric light bulbs.
5. Dust walls.
6. Fill liquid soap containers.
7. Repair wheel chairs.
8. Repair overstuffed furniture.
9. Clean and refill fire extinguishers.
10. Remove blackout paint.
11. Varnish M.C. benches and stools.
12. Clean and wax rubber doors.
13. Wax table tops.
14. Chains on bathtubs.
15. Electric fans.

WALL WASHING

PROCEDURE:

1. Make a soap solution, using two handfuls of washing powder to one half pail of water. (Use a little more washing powder if wall is very dirty.)
2. Use scouring powder on stubborn spots.
3. Wash with a rotary motion. START FROM BOTTOM, UP. Finish even with the dado line.
4. Rinse with clear water at least three times.
5. Change rinse water often.
6. Never stop work in middle of wall; cut off at a good corner.

EQUIPMENT NEEDED:

2 pails
Washing powder
Scouring powder
Sponges (1 synthetic and 1 Rock Island)
Water

REPLACE RUBBER HUSHERS and DOOR STOP FEET (BUMPERS)

PROCEDURE:

1. Replace where absolutely necessary.
2. When bolt cannot be removed, please report to housekeeping office.

EQUIPMENT NEEDED:

Flat hushers (door knob type)
Flat screw-on type hushers
Screw driver
8 inch pliers
Bumpers

LIQUID SOAP DISPENSERS

PROCEDURE:

1. If the tank is empty, run some hot water through it to cleanse it.
2. Refill.
3. Clean the dispensing valve.
4. Wash off the outer container.

EQUIPMENT NEEDED:

Liquid soap (5 gallon can)
Small funnel (about 6 inch)
10 inch pipe wrench
Clean rags

SODA ACID FIRE EXTINGUISHERS (2½ gallon)

PROCEDURE:

1. Prepare yourself by wearing old clothes (in case you spill contents of extinguisher on self).
2. Collect fire extinguishers and bring to central location—near the slop sink.
3. Turn the extinguisher upside down, pointing hose in the sink, until it is empty.
4. Unscrew the top.
5. Take out the glass bottle and bottle cork.
6. Wash out thoroughly the inside of the copper extinguisher and especially see that hose is washed out with water by filling the extinguisher with plain water and screwing on the cap. Then turn it upside down, let the water run out through the hose, clean the cap threads with a brush and oil with rag.
7. Stand the extinguisher in a vertical position, put in 1 pound of bicarbonate of soda, then fill with plain water up to the level on the inside of the extinguisher—this level is a piece of metal projecting on inside about ¼ from the top down.
8. Pour in 4 ounces of sulphuric acid in the small bottle and put in the cork.
9. Insert the bottle in the holder and put in the extinguisher.
10. Screw on the cap tight.
11. Do not tip before hanging on the wall.
12. Clean and polish the outside brass.

REMOVE BLACKOUT PAINT

PROCEDURE:

1. Apply one coat of remover all over the glass and let it stand for approximately five minutes.
2. Apply second coat, as above.
3. Remove loose paint with scraper.
4. Apply remover again.
5. Rub with dry steel wool thoroughly.
6. Dip steel wool in rich soapy water and rub thoroughly.
7. Rinse with very mild soapy water.

EQUIPMENT NEEDED:

A.R.P. remover
Scraper
Steel wool
Soap powder
"Duet" cloth
2 pails
Rubber gloves

waste motion and misunderstanding as possible.

Some of these instructions, together with the list of jobs and the general rules for men volunteers, are reproduced herewith, with the thought that perhaps other executive housekeepers will find them of value in case their own boards of trustees are inspired to "go and do likewise."

Incidentally, since the volunteer program has gotten well under way, the housekeeper is finding that one of her principal problems is keeping up with her new helpers, who work with surprising speed and dexterity.

Housing the Housekeeper

Too often the housekeeping office can be found in the gloomiest most inaccessible spot in the hospital, in spite of the fact that the housekeeper must be in constant touch with practically every other department.

Another drawback of which housekeepers complain is lack of space for office work, for storage and for workshops.

Mrs. Blanche Watt, R.N., executive housekeeper of Evanston Hospital, Evanston, Ill., has outlined the space needs of the housekeeping department throughout the hospital. It would, of course, be necessary to adapt these suggestions to each individual hospital but they represent a basic ideal from which each housekeeper can work out her own needs—and then sell the idea to her administrator, if she can.

Location: The housekeeping office should be located on the ground floor, never in the basement. (There may be some discussion on this point.) The room should be light, airy and warm. It must be convenient to all entrances and exits, elevators, engine rooms and the various workshops.

Size: Generally, a room 12 by 15 feet is adequate, depending on the type and size of the hospital and the amount of work that is actually done from the housekeeper's office. If this room is to be used as a business office only, it could be smaller.

Equipment: Desk and chair for the housekeeper and desk, chair and typewriter stand for her secretary.

Clock and timeclock, if the size of the hospital permits the use of the latter.

File cabinet if employe records are kept in the office.

Desk or table and chair for use of applicants for jobs and for salesmen and visitors.

Bookcase or shelves to hold a few good text or reference books, trade catalogs and samples.

Cupboards for regular housekeeping supplies; housekeeping supplies for the head nurse's station (if they are dispensed from here), and housekeeping linens, such as curtains, dresser scarves, draperies and cushion covers.

Bulletin boards.

Telephone.

Wastebasket.

Floor covering.

Personal items as desired.

Storage: Ample storeroom space should be provided for rugs, furniture, mattresses, blankets and pillows.

On the ground or basement floor rooms should be allotted to housemen's trucks, mopping equipment, scrubbing, waxing and polishing machines, window washers' belts and equipment, vacuum cleaners, sweepers. Space should also be made for the storage of screens, storm windows, electric fans and other equipment used seasonally.

Utility rooms: On each floor, there should be at least one (or more if the building is large) utility or hopper room equipped with large hopper sink with hot and cold water; hooks for brooms and brushes; shelves for small tools; trash and waste paper cans. *All equipment should be kept off the floors.*

Employes' rooms: Rest or lounge rooms and toilet and locker facilities must be provided for housekeeping employes. These rooms should be kept clean and as attractive as possible.

"What's this? TREASON in a h

Patient: My good woman, since when is it treason to register a beef? Besides, you can just blame it on something I *ate*.

Nurse: Something you *ate?* Why, our dietitian serves grand meals!

Patient: Lunch and dinner, yes. But *breakfast!* Lady, breakfast isn't breakfast to me unless I get *the kind of cereals I eat at home!*

Nurse: Oho! You mean your wife has some special recipe.

Patient: Special recipe, my foot! She serves the cereals *almost everybody* goes for! POST TOASTIES, POST'S BRAN FLAKES, GRAPE-NUTS, GRAPE-NUTS FLAKES, and the new hot GRAPE-NUTS WHEAT-MEAL. They're the wonderfulest cereals that ever nestled in a bowl! Yep, the fastest-growing cereal line in the country!

Nurse: There, there, you poor little man. You'd better come along—we have nice quiet little jackets for people like you!

Patient: Hey, before you get rough, listen to this: these General Foods Cereals are jam-packed with whole-grain nourishment, the kind Uncle Sam's Basic 7 Foods Program recommends. Unrationed, of course! Tell that to your dietitian—*she'll* tell you I'm talking good sense.

Nurse: Sorry, I can't bother her. Dietitians are awfully busy these days, you know.

Patient: Hmmm—then she'll be glad to know that these cereals save work for the kitchen staff. You see, these cereals come specially packed for hospitals—in convenient individual single-serving packages *and* in economical big ones!

Nurse: How can you possibly know so much? You sound like a radio announcer!

Patient: Young lady, I *am* a radio announcer! And I

NEWS IN REVIEW

Changes Made in E.M.I.C. and Crippled Children's Programs to Meet Objections

WASHINGTON, D. C.—Five important changes in the method of paying hospitals under the Emergency Maternity and Infant Care and crippled children's programs were announced by the Children's Bureau on April 15 and are to be effective July 1. They are:

1. The per diem rates of payment are to be all-inclusive and to cover any service rendered by individuals who receive any remuneration (salaries, fees, commissions or maintenance) from the hospital for such services. Specifically listed are the use of delivery or operating rooms, drugs and casts, laboratory, x-ray, anesthesia and physical therapy.

2. The cost of nursing education can be included as an operating expense as well as the cost of maintenance of student nurses and members of religious orders who serve in the hospitals. Income from federal or state public health agencies for nursing education must, of course, then be deducted from expense.

3. The salary and maintenance of a chaplain and the cost of maintaining a chapel can be included in expense.

4. A sliding scale is provided for the application of the 85 per cent formula to determine ward costs. For example, a hospital that provides from 98 to 100 per cent of its patient days in rooms with two or more beds (excluding infant days) can use 100 per cent of calculated cost as the reimbursable cost. If 84 to 86 per cent of the days are in such beds, 93 per cent of the total cost is reimbursable. A table covers other amounts.

5. A new formula is provided for the computation of the cost of an out-patient visit. This follows closely the A.H.A. accounting manual and includes the 10 per cent allowance for depreciation of buildings and equipment, rent and interest that is already included in in-patient cost. A maximum cost per visit can be set by the state agency. If a hospital is unable to compute its actual out-patient costs, it can estimate them at $1.50 each. The total amount claimed for out-patient costs must then be deducted from total costs to obtain the in-patient costs.

These changes meet most of the objections that hospitals have raised to the previous method of calculating costs. The only major objection remaining is that maternity care usually costs more than other types of hospital service.

Veterans to Get Fort Meade

WASHINGTON, D. C.—The facilities of Fort Meade, South Dakota, were transferred to the Veterans' Administration April 15 for use by that agency in treating sick and wounded veterans. It is the first of several anticipated transfers by the Army of installations which at present are not needed for training because of troop movements overseas. Fort Meade can accommodate approximately 2000 men.

Navy Nurses in Various Theaters

WASHINGTON, D. C.—Under the command of Lt. Cmdr. Mary Martha Heck, 100 Navy nurses reported for duty at Navy headquarters in England, February 7. They were assigned to a hospital staffed by 65 Navy doctors, four dental officers and 500 hospital corpsmen. Fifty Navy nurses landed in Guadalcanal the last week of March, 50 in the Russell Islands, 27 in Tulagi and 25 somewhere in North Africa.

W.P.B.'s Eased Restrictions on Metal Means Products of Better Quality

By EVA ADAMS CROSS

WASHINGTON, D. C.—W.P.B. orders are easing restrictions on many metals.

The use of metals is now permitted in *incandescent lighting fixtures* of the industrial type and restrictions were relaxed in other types, such as those designed for use in offices, hospitals and stores through amendment of L-212, March 15.

On April 13 *fluorescent lighting fixtures* were permitted metal in reflectors and more ferrous material in other parts of these fixtures.

A slight increase (25 per cent) in the production of *bedsprings and box springs* was permitted March 16 and the use of more steel per unit was allowed to improve the quality. Except for hospitals, the manufacture of metal beds, metal bed frames and innerspring mattresses for civilians is still prohibited. No specific production rate has been established for hospital *metal beds* (including those with fabric spring or adjustable spring), nor have restrictions been placed on their sale. They may be sold not only to hospitals but for sickroom use in homes. Hospital innerspring mattresses may be made to the extent that materials are available but only on specific orders from hospitals and sanitariums.

More extensive use of chrome stainless steel was granted March 24 to flatware manufacturers, thus ensuring hospitals that *knives, forks, spoons and similar implements* will be improved. On March 31, *stainless steel for cutlery* was made available, types most affected being those used in kitchens and table cutlery with plastic or wood handles.

Iron and steel, through amendment of L-13-a, March 24, may be used to produce *metal visible reference panels* for general office and industrial use to the extent of 40 per cent of the amount consumed for the same purpose in the year ending June 30, 1941. Some 400,000 will be produced at this rate. Such panels are used for ready reference to personnel records, telephone listings and similar lists.

Domestic cooking appliances and domestic heating stoves (not including electric stoves) will be more durable through the revision March 24 of L-23-c which removes restrictions limiting the weight of iron and steel in such products. The stoves will be more serviceable but there will be no thermostats, thermometers, high shelves, clocks or aprons.

Nursery scales may now be equipped with metal trays through certain specific changes made in L-190 on March 23.

A slight liberalization of M-126 (iron and steel) on March 31 permits within a certain percentage the making of *awning frames and supports and commercial size mop wringers.*

Restrictions on the use of ball bearings and other alloy steel products in swivel bearings and casters of *two-wheel hand trucks, platform trucks and dollies* were lifted April 1 through amendments to L-111. Cast steel for wheels and cast iron and steel were also permitted for other uses in the manufacture of these items. Book trucks, dish trucks, food carts, laundry trucks and laundry truck tubs, linen trucks and shelf trucks are all included. Hospital carts are exempted from the control of the order.

Sterilizer equipment came in for improvement April 3 through the easing of restrictions on the use of copper and copper base alloys. These metals may now be used without restriction in the production of all types except nonpressure instrument sterilizers. This amendment of L-266 will result in better sterilizers and the saving of manpower. The types of equipment thus improved include nonpressure utensil sterilizers, baby bottle pasteurizers and sterilizers, bedpan

steamers, bedpan sterilizers of the boiling type and bedpan washers.

Enameled sauce pans, sauce pots, pus basins, bedpans and instrument trays may be made in a wider variety of sizes, and production of *enameled dippers and metal covers* for enameled steam-table pans is to be resumed through amendment of L-30-b on April 3.

Quality and performance of *safety switches, panel boards and service entrance equipment* are to be improved through lifting of all restrictions April 3 on the gauge of steel in the manufacture of such equipment. Order L-315 was amended.

Navy Hospitals Lead Way in Programs for Senior Cadet Nurses

WASHINGTON, D. C.—The first classes for senior cadet nurses in the Navy started April 1 at the naval hospital at Seattle with seven students and at the naval hospital at Chelsea, Mass., with 20 students. Naval hospitals at St. Albans, N. Y., and Oakland, Calif., began classes May 1 with an enrollment of 25 students each. Naval hospitals at Portsmouth, Va., and at San Diego, Calif., will start classes June 1.

Lt. Jean Byers is directing the training of the cadet nurses in the Navy, which is the first of the federal services to put the cadet nurse corps program into practical operation.

Veterans' Administration hospitals are making the necessary arrangements to participate in the program, according to Gwen Andrew, superintendent of nurses. A pamphlet is under preparation. A special inducement is that the demand in this service for qualified nurses will increase in the future.

Several veterans' hospitals have established affiliate courses for student nurses.

At Hines, Ill., students are affiliating in orthopedic nursing, operating room technic, surgical nursing, and eye, ear, nose and throat nursing. The facility at Murphreesboro, Tenn., will accommodate 12 students from Vanderbilt University School of Nursing in an eight weeks' affiliation in psychiatric nursing. For the training of Negro nurses the facility at Tuskegee, Ala., has an eight weeks' affiliation in psychiatric nursing with John Andrew Memorial Hospital.

The amendment to the Bolton Act, which will determine the stipend to be paid U. S. Cadet Nurses in the federal services, is on its way through legislative and executive mills. Passage of this amendment is temporarily delaying the initiation of the cadet training program in some federal services.

Health Insurance Debate Precedes Drive for Bill

WASHINGTON, D. C.—Representatives opposing and favoring national health insurance took part in a forum held here April 7.

Senator James Murray explained the Wagner-Murray-Dingell Bill now pending. Other speakers were Dr. Harvey B. Stone of the A.M.A. Council on Medical Education and Hospitals; Dr. Joseph Mountin, assistant surgeon general, U. S. Public Health Service, and Robert Lamb of the C.I.O. social security council. The forum, held in the Department of Agriculture auditorium, was sponsored by a group of medical, labor, business and professional organizations.

Doctor Mountin presented a noncontroversial analysis of the subject. Senator Murray and Mr. Lamb supported the bill vigorously and Doctor Stone opposed it. Similar discussion groups have recently been held in Detroit and other cities, indicating that a concerted drive to effect the passage of the bill is now under way.

In a radio broadcast from New York City, Senator Wagner on March 19 denied that the bill involves regimentation of either doctors or patients. He said that free choice for both was fully preserved. The bill simply puts "our medical care problem on the same basis as public education," he declared.

Voluntary Insurance Fails, Murray States; Health Law Is Essential

"Voluntary insurance has always and everywhere, here and abroad, failed to do the basic job. It has to be done through compulsory insurance."

Thus does Sen. James E. Murray of Montana, one of the sponsors of the Wagner-Murray-Dingell Bill, attempt to minimize the work of Blue Cross and other voluntary plans in an article in the March 26 issue of the *Worker*. His article is based on an address at the second health conference of the C.I.O. United Automobile Workers Medical Health Institute held in Detroit.

"Even the unusually successful hospital service plans cover only about a tenth of our population. However, the rate of growth in the older plans is slowing down. Even if the Blue Cross plans continued to get as many members each year for the next ten years as they did in their very best year, at the end of such a ten year period about three quarters of our population would still be without insurance protection.

"A system of medical care and hospitalization insurance, developed as part of a national social insurance system, would cover between 80 and 90 per cent of our population in the first year. It is tremendously important that we have a strong social security system in operation at the war's end."

Senator Murray states that his bill will pay fair amounts to doctors and hospitals, will increase the amount of service they can render and will improve its quality.

Social security, he says, "is not a distant goal toward which we can afford to move slowly and gradually, with due regard for the convenience of vested interests. Ten years, five years from now may be too late." He declares that poor health is "ordinarily the most common cause of economic insecurity."

Latest Ruling on Intern and Student Deferments

WASHINGTON, D. C.—National headquarters of Selective Service instructed state directors April 11 concerning the deferment of registrants 18 to 26 years in four specific groups, three of which are students and the other, interns. These instructions rescinded those of April 4.

State directors will recommend exceptions to the general restriction against the occupational deferment of certain students and interns in the 18 to 26 year old group by indicating on special forms their recommendation and the deferment time.

Of special interest to hospitals are the three following groups: registrants pursuing full-time courses of study in medicine in recognized schools of medicine until their graduation; registrants pursuing full-time courses of study in premedicine until their graduation if they are in recognized colleges and universities and provided such registrants have been accepted for admission in and will matriculate and enter into actual classroom work in a recognized school of medicine on or before July 1, 1944; registrants having completed their professional training and preparation as medical doctors and who are undertaking further studies in a hospital or institution giving a recognized internship, provided the total period of such internship shall not exceed nine months.

Guy Clark Honored on Anniversary

Guy J. Clark, executive secretary of the Cleveland Hospital Council, was honored by health leaders in Cleveland on the occasion of his twenty-fifth year of service with the council on April 12. Mr. Clark has been affiliated with the association since 1919 and became its executive secretary in 1927. Gifts, including a wrist watch, shotgun, traveling case and war bonds, were presented to Mr. Clark through Raymond G. Bodwell, president of the council.

OFFICIAL ORDERS
March 15 to April 15

Aluminum.—Aluminum closures for parenteral solutions and blood or plasma, and the use of aluminum in hospital operating room lights, orthopedic, medical, dental, ophthalmic and surgical instruments and equipment, x-ray equipment, infra-red and ultra-violet lamps are permitted by Amendments to Order M-1-i made on March 24.

Bathtubs.—Some 50,000 cast iron bathtubs are slated for production during the second quarter of 1944, W.P.B. announced on March 31. Distribution of the tubs is limited but hospitals with authorized preference ratings may obtain them.

Clocks.—Approximately 1,200,000 war model alarm clocks will be manufactured in April, May and June, W.P.B. announced April 1. Many of them must go for military needs. A limited quantity of inexpensive nonjeweled wrist watches will be earmarked for distribution to nurses, student nurses and nurse's aides.

Drugs.—Drug manufacturers may not raise ceiling prices on products manufactured with ethyl alcohol over those originally established at the March 1942 level as a result of the increased federal tax on that alcohol, which became effective April 1, O.P.A. announced on March 17. Although the tax was recently increased it is now lower than in March 1942.

Electric Connections.—Installation of new electric connections, both urban and rural, has been curtailed to protect productive capacity required for direct military use, according to a W.P.B. announcement of April 6. Additional changes in utilities orders modify restrictions on extensions of gas and electric services for cooking purposes; permit extensions of utilities to all types of commercial and industrial consumers, including physicians' offices, and revise and simplify the utilities construction standards called for by U-1-f.

Flatware.—More chrome stainless steel has been permitted manufacturers in the production of knives, forks and other flatware intended for hospitals and other institutions, W.P.B. announced March 21. Since Nov. 5, 1943, stainless steel from distressed stocks has been permitted; prior to that date for a year and a half none was permitted except for military orders. Stainless steel flatware for home use is still prohibited.

Laundry Equipment.—A program for the production of $27,000,000 worth of commercial laundry equipment was approved by W.P.B. March 27. Approximately a third of the equipment will be available for nonmilitary use, the remainder for the armed services.

Lumber.—The possible effects of recently established lumber controls on the wood furniture industry were discussed March 30 with the Wood Furniture Industry Advisory Committee. Order M-361, southern yellow pine, and M-364, (now governing eight kinds of hardwood) since March 20 affect all sawmills producing over 5000 board feet per day and cutting any of the restricted species. The restricted species constitute only about half of all the U. S. hardwood production, the rest of the hardwood output remaining uncontrolled. Hardwood users, including furniture manufacturers, may draw upon it without specific authorization.

W.P.B. expects to control the distribution of about 75 per cent of the yellow pine output and 70 per cent of the restricted hardwoods instead of only 50 per cent of each as formerly.

A recent lumber order, L-335, requires all wood users who consumed more than 50,000 board feet of lumber in the fourth quarter of 1943 or who expect to consume more than this amount in either the second or third quarter of 1944 to file applications on WPB-3640 stating their lumber requirements for the second and third quarters on or before April 25. This information will enable W.P.B. to control the consumption of all lumber, instead of only certain species, in relation to the available supply and the relative essentiality of the purposes for which it is to be used.

Milk Sugar.—A W.F.A. milk sugar order, F.D.O. 95, effective April 1, requires approval by the director of food distribution for the use of milk sugar for any purpose. Since production this year is insufficient to meet requirements of all users, this order will direct milk sugar to the most essential uses. Total requirements for milk sugar in 1944, including those for infant foods, pharmaceuticals and penicillin, will be more than 15,000,000 pounds.

Photographic Equipment.—Controls over production and distribution of restricted photographic equipment, accessories and parts for nonmilitary orders have been relaxed slightly, W.P.B. announced on March 17. X-ray tanks, film developing hangars, illuminators, driers and film cabinets are specifically excluded from the limitations of the order. Any other equipment covered by the x-ray order (L-206) is also excluded.

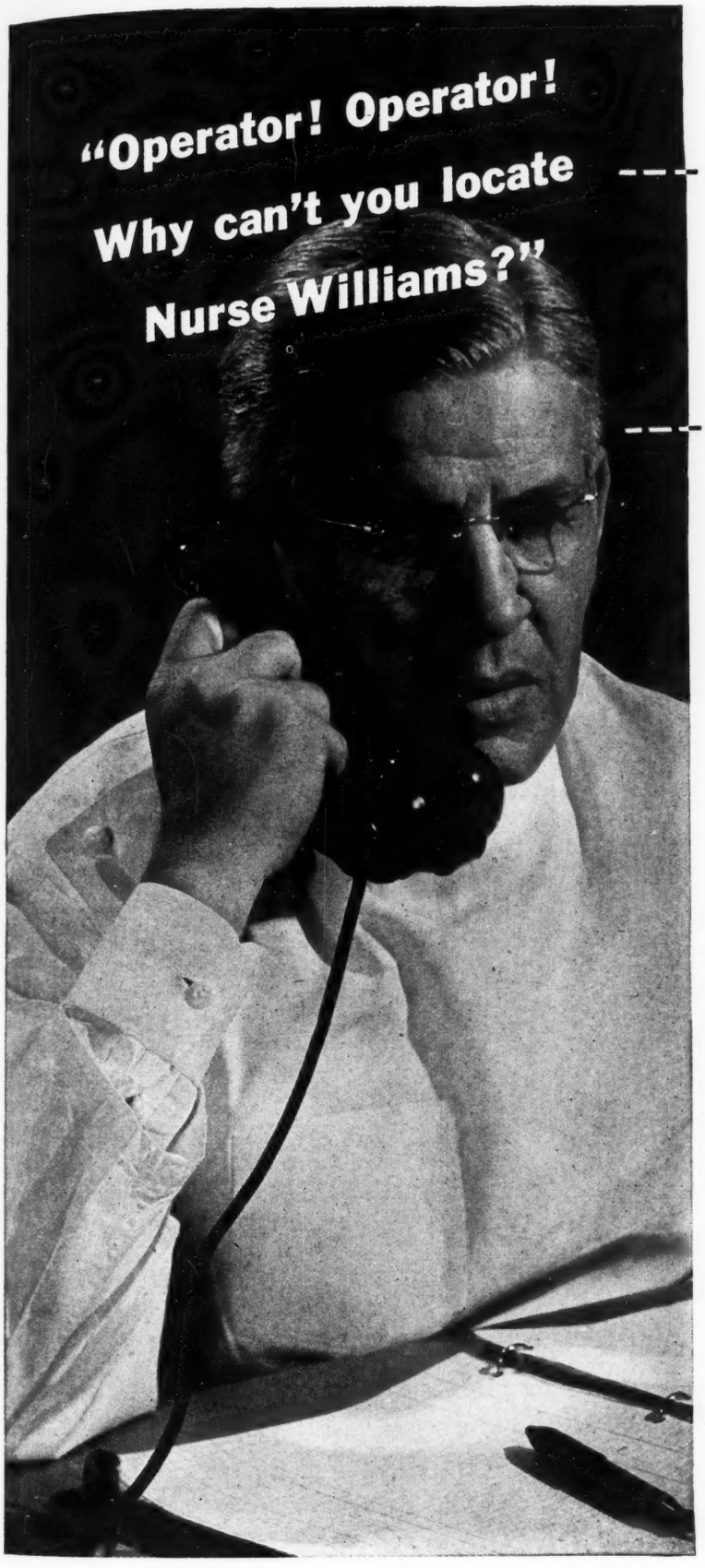
Physical Therapy Equipment.—Restrictions on the manufacture and sale of physical therapy equipment were eased April 7 through amendment of L-259. Medical practitioners and hospitals may now buy certain types of equipment formerly manufactured only for the armed services and lend-lease; physicians may now buy, in addition, other types formerly restricted to these groups and hospitals. Three types of this equipment, generally approved by the medical profession for home use, may now be sold to the public on prescription.

Among types that may now be manufactured and sold to hospitals, to medical departments of industrial concerns and to physicians are: electric bakers, fever cabinets, galvanic generators, infra-red generators, low voltage generators, magnetic field generators, medical diathermy units; passive vascular exercise apparatus, surgical diathermy units, ultra-violet radiation equipment and whirlpool baths.

Plumbing Fixtures.—Limited production of copper ball cocks for plumbing fixtures was permitted by amendment on April 5 to Order L-42. Several other plumbing items were also authorized. On April 12 the order was further amended to permit metal to be used for plaster and grease interceptors.

Roofing and Siding.—An interpretation April 5 to construction order L-41 clarified the provisions concerning re-siding and re-roofing. If an existing siding or roofing needs repair, the minimum amount of repair work may be done to put the siding or roof in a suitable condition. However, if a siding can be put in proper condition by painting, that should be done. If the siding has so deteriorated that a paint job will not provide adequate protection, a new siding may be applied. The new siding need not be of the same material as the old. This interpretation is not applicable where asbestos materials are used for re-siding or re-roofing as the use of these materials is governed by L-41-d.

Thermometers.—Standardization restrictions on the production of general purpose thermometers were removed March 17. General purpose thermometers include such types as cylindrical case, sterilizer, hot-water, open "v" case, and shower bath thermometers.



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49 Nurses' Homes, and Training Facilities Approved by President

WASHINGTON, D. C.—With a new appropriation of $115,000,000, the Federal Works Agency announced April 6 approval by the President of 277 new war public works and services projects. These projects are spread over 42 states, Alaska and Hawaii.

All construction projects must, in addition, be approved by W.P.B. before work can be started.

An allotment of $600,036 additional to help finance a second full year's operation of Chicago's rapid treatment center for venereal disease was announced also by F.W.A.

Some 49 nurses' homes and training facilities and hospital facilities were listed among the projects receiving presidential approval.

Among the larger nurses homes and their total costs are the following approved by both F.W.A. and W.P.B.:

Methodist Hospital, Gary, Ind., $200,000; Michael Reese Hospital, Chicago, $295,325; Mercy Hospital, Oshkosh, Wis., $79,500; Mercy Hospital, Nampa, Ida., $26,000; River Pines Sanatorium, Stevens Point, Wis., $25,970; Midway Hospital, St. Paul, $57,000; Ohio Valley General Hospital, Wheeling, W. Va., $43,590; St. Rita's Hospital, Lima, Ohio, $34,000; St. Mary's Hospital, Saginaw, Mich., $216,495, and St. Joseph's Hospital, Wichita, Kan., $165,000.

Other large approved projects in non-federal hospitals include:

Presbyterian Hospital, Chicago, $200,000; San Diego County, Calif., $196,000; General Hospital, S. Charleston, W. Va., $619,875; St. Francis Hospital, Huntington Park, Calif.; $600,000; Tuskegee Institute, Tuskegee, Ala., $330,000; Western State Hospital, Bolivar, Tenn., $119,900; San Bernardino County Hospital, San Bernardino, Calif., $232,245; People's Community Hospital, Eloise, Mich., $132,645; Tri-County Hospital, Tullahoma, Tenn., $372,750; Gallinger Hospital, Washington, D. C., $225,750; St. Joseph's Hospital, Detroit, $225,000; Villa Maria Hospital for Sisters, Wernersville, Pa., $257,896; Philadelphia State Hospital, $539,980.

Can More Food This Year, War Food Officials Urge

Civilian organizations are urged to carry on an extensive food canning program this summer because the amount of canned fruits and vegetables that must be set aside for the armed forces has been increased, the War Food Administration announced on March 23.

The government has reserved 92,000,000 cases of canned vegetables and 36,000,000 cases of canned fruits and fruit juices from the 1944 pack. This is an increase of 35,000,000 cases of vegetables and 14,000,000 cases of fruits over the 1943 amounts.

A consultant and advisory service has been set up in the Midwest regional office of distribution of W.F.A. and doubtless in other offices to assist in meeting technical problems of groups interested in canning. Surplus commodities may also be canned for the use of voluntary and governmental hospitals that are eligible under the surplus foods distribution program.

Legion of Decency Objects to Public Health Service Film

WASHINGTON, D. C. — Modifications are to be made in the film, "To the People of the United States," to conform to objections made by the Legion of Decency, according to an announcement by Dr. Thomas Parran, surgeon general of the U.S.P.H.S.

The legion maintained that the film, which deals with venereal disease, would pave the way for a flood of pornographic pictures and that, while dignified and restrained, it does not stress the fact that promiscuity is the principal cause for the spread of venereal disease.

In addition to minor changes in the film, its distribution will be limited to private groups, such as health departments, hospitals, voluntary health agencies and Army posts. It is sponsored by the U.S.P.H.S.; Doctor Parran presents the introductory remarks and Jean Hersholt heads the cast.

Two Day Southeastern Meeting Sets Record for Large Attendance

A warning that the habits being established in war time may cause many difficulties and headaches in the coming peace was sounded by W. E. Arnold, executive director of St. Luke's Hospital, Jacksonville, Fla., before the eighth annual meeting of the Southeastern Hospital Conference at Atlanta on April 12 and 13. The abbreviated conference, with a registration of more than 300, was the best attended in the history of the organization.

"What habits are we building up as regards high salaries and other concessions to employes, loss of discipline, dependence upon volunteers, use of interns and nurses to do the work of physicians and increase in government influence and control over hospitals? Will these habits become ruinous in peace time?" This was Mr. Arnold's theme.

He mentioned particularly the cadet nurse corps, wage and hour administration, W.P.B., W.L.B., P. & A.S., E.M.I.C., Office of Vocational Rehabilitation and other federal and state agencies.

J. B. Franklin of John D. Archbold Memorial Hospital, Thomasville, Ga., answered in part Mr. Arnold's queries when he stated that much of our present trouble is due to the failure of hospitals in the past to pay proper salaries. He declared that the public is ready to pay rates that permit such salaries.

In spite of Mr. Arnold's fear of federal agencies, representatives of various federal groups affecting hospitals took prominent parts in the program. Among the agencies represented were O.C.D., P.&A.S., the state health department, the state division of vocational rehabilitation, W.M.C., P.&A.S. for Nurses and U. S. Cadet Nurse Corps.

The American Hospital Association was also represented by four speakers. Kenneth Williamson, secretary of the council on association development, reported that only 30 hospitals of the 3200 A.H.A. members have refused to pay the increased dues. He urged all state associations to affiliate with the A.H.A.

The conference endorsed the A.H.A. expanded program, approved the resolution on Blue Cross and care of the indigent adopted by the A.H.A. at Buffalo, urged that the federal government dispose of any surplus equipment through regular dealers without profit and requested the A.H.A. to compile a standard report form for all government bureaus.

Mr. Arnold was chosen as president-elect of the conference and Dr. W. L. Shackleford of Jefferson Hospital, Birmingham, Ala., as secretary-treasurer, The new president is Dr. Henry Hedden of Methodist Hospital, Memphis.

Georgia Hospital Association officers elected are: president, Sister Mary Cornile, St. Joseph's Hospital, Atlanta; president-elect, Fred M. Walker, Grady Hospital, Atlanta; secretary-treasurer, C. J. Anderson, United Hospitals Service Association, Atlanta; trustee, H. L. Wilson, Floyd Hospital, Rome.

Propaganda Bureau Is Called United Public Health League

The name of the Western States Public Health League has been changed to the United Public Health League. The first formal meeting of the league will be held in Los Angeles in May at the time of the California Medical Association's convention.

Dr. A. J. J. Rourke, a member of the California delegation, reports that the majority of the medical societies of the western states have endorsed this venture. The Washington State Medical Society trustees as well as those of Oregon, however, have disapproved the organization. The former urged physicians to exercise their influence in Washington through the American Medical Association.

New in This War Are Surgical Teams That Go to Front Lines to Work

WASHINGTON, D. C.—Auxiliary surgical groups, new in this war, take surgery to the front lines to ensure prompt treatment of wounded men by experts, according to the War Department.

As presently constituted, each such group is composed of more than 50 teams and other personnel. About half of them are general surgical teams; the remainder are specially qualified to do orthopedic, maxillo-facial, nerve, chest or brain surgery.

The personnel of each team varies according to the job it is called on to do. A general team may consist of a general surgeon, an assistant surgeon, an anesthetist, a nurse and two surgical technicians. With them go truck drivers and other assistants needed for whatever situation confronts them.

The teams are organized like firemen and are available for duty when and where they are needed. They are not burdened with routine medical duties and are not attached to a particular organization.

On call at all times, these teams may be assigned by the theater surgeon to go anywhere in a battle area. They travel in trucks, supply vehicles, in jeeps or by plane.

In jungle areas portable surgical hospitals have been organized. These teams load all their instruments on their backs and transport them as far forward as they are allowed to go. There they set up their hospitals under canvas.

McGrath's Rhode Island Plan Deferred to 1945

At the suggestion of Gov. J. Howard McGrath the Rhode Island Voluntary Advisory Council on Health recommended on April 10 that the enactment of a compulsory hospital care bill in that state be deferred until the 1945 session of the legislature.

The governor requested the extension of time to permit opportunity to study the proposal more fully and to formulate a bill more carefully. In the meantime he recommended that the Blue Cross plan should expand its coverage in every way and that all related groups do everything possible to encourage enrollment in the Blue Cross under its expanded plan.

To give immediate encouragement to voluntary hospital insurance, the governor asked the legislature for authority to enroll all state employes in the Blue Cross with the state paying the cost. Employes would then be permitted to enroll their families at their own expense. This bill was introduced on April 11. It would empower cities and towns to take the same action as the state.

Another bill asked the Rhode Island Medical Society to sponsor a voluntary nonprofit plan for medical and surgical insurance. Although the bill regarding state employes passed the House, it was lost in the last minute log jam.

Stanley H. Saunders, executive director of Hospital Service Corporation of Rhode Island, reported that the plan is immediately proceeding to develop a more liberal contract as suggested by the governor.

Tighten Up on Quinidine Use

An alarming diminution of the stocks of quinidine was revealed in a recent release of the National Research Council which recommended last September that the dispensing of the drug be limited to certain types of heart disease on a doctor's prescription. In spite of the recommendation, however, the stocks have continued to dwindle to the point at which it seems probable that unless drastic steps are taken the supply of quinidine will be completely exhausted within the next few months. The council is urging hospitals to tighten up on the use of this material in order to conserve it to meet minimal needs for the near future.

Nurse Teachers Sorely Needed; Dispute Over Blue Cross Contracts

The shortage of trained instructors and supervisors in New York City hospitals was pointed out by Sister Loretto Bernard, St. Vincent's Hospital, at the last meeting of the Greater New York Hospital Association.

While the number of students admitted to schools of nursing in 1943 increased 40 per cent over 1942, there has been a marked decrease in the personnel training them. This is attributed to the fact that Procurement and Assignment Service for Nurses was not in operation last year with the result that many qualified teachers have been lost either to the military services, to industry or to other jobs.

An urgent appeal was made to all hospitals to cooperate with the Red Cross program for recruiting nurses for the Army. Of a quota of 499 assigned to the greater New York area, the recruitment service has been able to supply only 149 since January 1.

A joint committee representing the New York State Hospital Association, the state medical association and the Blue Cross plans has been appointed for the purpose of endeavoring to standardize Blue Cross plan contracts. A cleavage has developed between the medical groups and the hospitals because the doctors are adamantly opposed to the inclusion in the Blue Cross contracts of benefits covering medical services, such as physical therapy, anesthesia, laboratory and x-ray, if the contracts do not now cover such benefits. They demand the removal of any such benefits from contracts which now contain them.

A report submitted by the chairman of the state association committee recommends that the hospitals continue to accept contracts that include medical items and that those procedures which have been carried out by hospitals in the past and which are accepted as standardized hospital procedures continue to be accepted as such.

Navy's Largest Hospital Ship Is U.S.S. Refuge

WASHINGTON, D. C.—The Navy's newest and largest hospital ship, the *U.S.S. Refuge,* was inspected by V/A Ross T. McIntire at Baltimore March 5.

Complement of the *Refuge* includes 20 medical officers; three dental officers; a volunteer specialist officer in charge of the optical repair unit, the first of its kind on a hospital ship; 29 Navy nurses; a Red Cross representative; 14 chief pharmacist's mates, and 200 hospital corpsmen. Lt. (jg) Mildred Marean is chief nurse.

As to equipment, the *Refuge* has fixed berths for 630 patients, a mobile field hospital of 72 cots, a laboratory, x-ray equipment, medical and surgical equipment and supplies.

There are 12 wards each with a surgical dressing room, diet pantry, utility room, linen locker, toilet and shower. The laboratory holds a high-speed centrifuge, bacteriologic incubator and autoclaves as well as a laundry and a refrigerator. There are also a pharmacy, dental clinic, physical therapy department and a clinic for eye, ear, nose and throat.

Latin Americans Not in Quota

Graduates of Latin-American medical schools who are currently serving as interns or residents in United States hospitals are not to be counted in hospital quotas, it has been decided by the directing board of Procurement and Assignment Service. Inasmuch as it is desirable to have Latin-American physicians seek postgraduate medical training in the United States, dropping them from hospital quotas would encourage hospital administrators to accept them as interns and residents and thus facilitate their obtaining additional training.

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British Hospitals to Grant Reforms to Domestic Workers

New minimum pay standards and improved working conditions for domestic service in British hospitals have been evolved by a committee and adopted by the government.

Besides a minimum wage for all domestic workers, British hospitals and institutions must provide adequate canteen facilities for the nonresident staff. A ninety-six hour, two week period for all resident and nonresident personnel will be adopted and overtime will be paid if time off cannot be given during the succeeding fourteen day period. Overtime pay will be at time and a quarter of the nonresident employe's hourly rate.

Plans for granting holidays and sick leave include: one week's vacation with pay, after six months' continuous service, plus six statutory days off; sickness payments ranging from six weeks' full pay and three weeks' half pay after six months' service to nine weeks' full pay and nine weeks' half pay for those with three or more years of service.

The Ministry of Labor will provide training to ensure a good standard of skill.

Ohio Delegates Discuss Payment for Indigent Cases

Lee S. Lanpher, administrator, Lutheran Hospital, Cleveland, took office as president of the Ohio State Hospital Association at its annual meeting in Columbus, March 21 to 23.

New officers elected were: Van C. Adams, Jewish Hospital, Cincinnati, president-elect; George Gilles, Memorial Hospital, Fremont, first vice president; Sister Francis Maria, Good Samaritan Hospital, Dayton, second vice president, and Msgr. Maurice F. Griffin, Cleveland, reelected treasurer.

Speakers on the program included Herbert R. Mooney, director, Ohio State Department of Public Welfare; E. A. van Steenwyk, Associated Hospital Service of Philadelphia; Everett W. Jones, vice president, The MODERN HOSPITAL, and Dr. Homer A. Anderson, resident physician, Children's Hospital, Columbus.

Speaking at the luncheon meeting on March 21, Mr. Mooney acknowledged that hospitals are underpaid in their work of caring for the indigents of the state and paid tribute to the state association for its help in working out procedures to be followed by the department of public welfare and the hospitals. Mr. Jones' paper also dealt with care of indigents and he pleaded for understanding cooperation between units of government and voluntary hospitals.

The session of the Ohio Society of Hospital Pharmacists was addressed by Doctor Anderson and by Esther E. Hege, director of nursing and nursing education, City Hospital, Springfield, who discussed the "Aims and Accomplishments of the Hospital Pharmacy and the Nursing Department."

Rapid Treatment Center Opened at Bellevue Hospital

A 200 bed rapid treatment center at which the most advanced treatments will be rendered without charge to persons suffering from venereal disease was opened at Bellevue Hospital, New York City, in March. Started more than a year ago, the center was built with $290,000 of F.W.A. funds; a further grant of $285,000 has been made for its maintenance, which will be sponsored entirely by the federal government during the war.

Correlated with the center will be a 100 bed rehabilitation center on Welfare Island that was scheduled for completion on April 1. Its program is expected to stress vocational courses, such as typing, radio repairing and garment making.

Dr. Evan Thomas, staff syphilologist at Bellevue, and Dr. Alfred Cohn, head of the city health department's gonococcus research section, will be in charge of treatment of patients.

Governor McGrath Will Tell Rhode Island Plan at Tri-State Banquet

"From Warfare to Welfare" will be the theme of the fifteenth annual Tri-State Hospital Assembly which will convene at the Palmer House in Chicago, May 10 to 12.

The broad subjects of the three general assemblies on Wednesday, Thursday and Friday mornings will be, respectively: "Serving the Patient and Community in War Time," "New Trends in Personnel Management in Hospitals" and "War-Time Problems in Procuring Food and Other Hospital Supplies." Speakers will include officials from various Washington bureaus, leaders in the hospital field and Blue Cross plan executives.

On Wednesday evening there will be a forum for all groups and sections of the assembly. Coordinators will be Dr. Robin C. Buerki, Dr. Roger W. DeBusk and the general chairman, Dr. Malcolm T. MacEachern.

Banquet speaker on Thursday evening will be the Hon. J. Howard McGrath, governor of Rhode Island, who will present the Rhode Island plan for hospital insurance. Following the governor's address, a reception will be held in his honor and military medical motion pictures depicting care of the wounded on battle fronts will be shown.

National Induction of Nurse Cadets

National induction of the U. S. Cadet Nurse Corps will be held on May 13 by the Division of Nurse Education, U. S. Public Health Service, in cooperation with the National Nursing Council for War Service. The program will be broadcast from Constitution Hall, Washington, D. C., over the NBC network from 4:30 to 5 p.m., eastern war time. While the national induction is taking place in Washington, cadets throughout the country will assemble in listening groups and will stand at attention as Surgeon General Parran administers the induction pledge to 700 cadet nurses assembled in Washington. Speakers will include Mrs. Franklin D. Roosevelt; Paul V. McNutt, F.S.A.; Mrs. Frances P. Bolton, Congresswoman from Ohio, and Lucile Petry, director of the U. S. Cadet Nurse Corps.

Army Hospital at Alaska U.

The University of Alaska, Fairbanks, will soon be in service as an Army hospital. Under the direction of the Army Engineer Corps, a group of civilian workmen and a detachment of engineer troops are remodeling leased buildings and constructing others for medical corps needs. The cost of the project is estimated at about $175,000. Men's and women's dormitories, a club, the administration building and the Edison Memorial Building have been taken over by the Army. College classes are concentrated in the remaining buildings.

New Wing for Paterson General

Paterson General Hospital, Paterson, N. J., of which Edgar C. Hayhow is superintendent, now boasts a new women's and children's pavilion, which was rebuilt from the Paterson orphanage. Approximately $540,000 was spent on the project, of which $360,000 came through a F.W.A. grant. The building has a total floor area of about 54,000 square feet laid out to give a total of 210 beds and bassinets, thus making it one of the largest voluntary hospitals in the state. Frederick J. Vreeland is the architect.

A.M.A. Publicity Office at Capital

An office of information will be opened in Washington, D. C., by the A.M.A. Council on Medical Service and Public Relations. The office will be under the direction of the council and for the time being will be under the direct charge of Dr. Joseph S. Lawrence, Albany, N. Y.

Nurses' Status Must Be Reappraised, Bluestone Tells Hospital Fund

Of the many subjects discussed during the one day symposium sponsored by the United Hospital Fund in New York City, the status of nursing proved the most revealing and controversial.

As Dr. E. M. Bluestone, director, Montefiore Hospital for Chronic Diseases, New York City, expressed it, men and women are taking sides on the cause and cure of this malady and the nursing profession itself is split wide open on the issues. Meanwhile, the patient waits.

Doctor Bluestone enumerated 10 points which, in his opinion, deserve particular emphasis. Some of these are: (1) We must redefine nursing in terms of bedside care; (2) we must identify and classify the nursing specialties and plan separately for them with bedside nursing as a prerequisite to a higher education; (3) we must formulate the duties of the bedside nurse and the nurse specialist in detail before we proceed to draw up a program for their education; (4) we must determine an optimum point in our patient-nurse ratio that will be acceptable to all; (5) we must draw up wage scales and perquisites, including a pension system that will place the bedside nurse on a level of economic safety; (6) above all, we must avoid the two extremes of undereducation and overeducation with which we have already had such bitter experience in the past.

The remarkable achievements in military medicine, as exemplified in various war theaters, were described by Brig. Gen. Fred W. Rankin, chief surgical consultant, U. S. Army Medical Corps, and Capt. French R. Moore, Medical Corps, U. S. Navy. Ninety-seven out of every hundred soldiers wounded in battle are being saved from death; out of every 10 wounded in the abdomen, doctors are saving from seven to eight.

Among other significant subjects presented was a concrete example of medical group practice as evidenced in the organization of the Mary Hitchcock Memorial Hospital, Hanover, N. H. A discussion of this project by Dr. John P. Bowler and Dr. Leslie K. Sycamore will be found on page 46.

Leaves $70,000 to Alexandria Hospital

Alexandria Hospital, Alexandria, Va., was named residuary legatee in the will of Mrs. Virginia L. Simpson, widow of George H. Simpson, one time mayor of Alexandria. It is estimated that after cash bequests in the will and expenses have been paid the balance will amount to about $70,000. Mrs. Simpson stipulated that the fund provide at least two free beds for indigent care.

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2208 Hospitals Use Nurse's Aides; Need Dietitian's Aides

EVA ADAMS CROSS

WASHINGTON, D. C.—Nurse's aides now serve in 2208 civilian hospitals, 27 veterans' hospitals, 103 Army hospitals and dependents' wings of Navy hospitals, Mrs. Walter Lippmann announced April 2. Approximately 120,000 women have passed an eighty hour training course for nurse's aides since July 1941, when O.C.D. asked the Red Cross to undertake this training on a large scale.

The volunteer dietitian's aide program initiated in April 1943 now numbers 2500 dietitian's aides serving in 29 states in Army, Marine and veterans' hospitals as well as in civilian hospitals, according to Mrs. Graham Dougherty of the American Red Cross, who reports a crying need for more volunteers.

Blue Cross Plans Report Biggest Quarter in History

The largest growth in enrollment of Blue Cross plans in history occurred in the first quarter of 1944 when 801,000 net additions were made. This exceeds by more than 200,000 all previous enrollment records for a similar period.

The total national membership of the 77 approved plans in the United States and Canada now stands at 13,807,000, exclusive of more than 600,000 suspended contracts for members of the armed forces.

Largest growth for the quarter was recorded by the following plans: Boston, 97,900; New York City, 85,000; Philadelphia, 35,000; Canton, 31,000; Toronto, 30,000; Pittsburgh, 28,000; Detroit, 27,000; St. Louis, 26,000; Moncton, 26,000, and Chicago, 23,000. Sixteen other plans gained from 10,000 to 20,000 members during the quarter.

A meeting of plan executives from Illinois, Missouri and Iowa was held in Chicago on April 17 to discuss possibilities of uniform contracts for the three state area.

A considerable number of plans have reported that their boards have approved the proposal to pay 1 per cent of earnings for a national publicity and advertising program. Several of the larger plans are included.

Annual birth rates per thousand participants in Blue Cross plans dropped sharply from 24.2 in 1943 to 18.2 in 1944, the commission recently reported.

Leaves $50,000 to Michael Reese

At least $50,000 has been left to Michael Reese Hospital, Chicago, under the will of Jessie F. Sutton, 58, who died April 4. Other charitable bequests made by Miss Sutton include $25,000 to the Jewish Charities and $5000 to the Visiting Nurse Association, Chicago.

Pennsylvania Group Hears Hoge Urge Health Committee

A state health planning committee representing hospitals, physicians, public health services, the architectural profession and the public should be set up now in each state to prepare for the postwar construction of hospitals and other health facilities, Dr. Vane M. Hoge, U.S.P.H.S., told the Hospital Association of Pennsylvania at the annual meeting in Pittsburgh, April 12 to 14. He also urged the coordination and integration of hospital facilities. His talk will appear in a forthcoming issue of The MODERN HOSPITAL.

The use of punch cards in the medical records department of Elizabeth Steel Magee Hospital, Pittsburgh, effects a great saving of time when analyses are wanted by members of the medical staff, Betty S. Neeld stated in the joint session with the medical record librarians. For example, a complete analysis of 350 obstetric cases can be made in one day, whereas hand methods would take two people three or four days. Much time is saved in the pulling and refiling of charts.

More payment to hospitals from government funds was advocated by Dr. Donald Smelzer in his presidential address. Hospitals should work together to obtain payments equivalent to cost. The state rate in Pennsylvania has recently been increased from $3 to $3.50 per day. He expressed a hope that it would soon be increased to $4.

Officers elected are: president-elect, Esther J. Tinsley, Pittston Hospital, Pittston; president, Raymond V. Hosford, Bradford Hospital, Bradford, and treasurer, Elmer E. Matthews, Wilkes-Barre General Hospital, Wilkes-Barre. S. Hawley Armstrong was reappointed as secretary.

Rank for Navy and Army Nurses for Duration Only

WASHINGTON, D. C.—Navy nurses have been granted actual rank for the duration, said Commander Elizabeth O'Brien in an interview April 7. Nurses will be designated by the commissioned rank corresponding to present relative rank.

Permanent actual commissioned rank is not favored by the Army at this time, Mr. Stimson told the House military affairs committee recently. Representative Frances Bolton has introduced a substitute for her permanent rank bill which would confer actual rank for the duration only as with the Navy nurses. Mrs. Bolton's bill provides for appointment of nurses, dietitians and physical therapists in the Army of the United States with actual rank corresponding to relative rank now held.

New York to Develop Master Plan

Preparation of a master plan for hospitals and related facilities was announced by the Hospital Council of Greater New York on March 26 as its major project for the coming year. The definition and scope of the plan were outlined in a statement issued by Edwin A. Salmon, chairman of the council, who is also chairman of the City Planning Commission. The plan should show, Mr. Salmon stated, all existing hospitals and institutions that are satisfactorily located and provide adequate facilities and distribution of clinical services for the future communities to be served; those that are satisfactorily located but require certain modifications and additions; all proposed new facilities that are deemed to be desirable, and hospitals that desire to be relocated, closed or merged with other hospitals.

Neurosurgeons Confer at Capital

WASHINGTON, D. C.—A four day conference of eminent neurosurgeons, including heads of the neurosurgical clinics of all the Army general hospitals and a few civilian specialists, ended here April 6. New uses of tantalum were demonstrated in operations, lecture slides and technicolor movies.

Farm Foundation to Establish National Program on Rural Health

A program for the improvement of rural health was discussed and a national committee on this subject was recommended at an informal conference of 90 rural leaders and technical specialists in health problems held in Chicago on April 11 to 13. The conference was called by the Farm Foundation of Chicago and was endorsed by the leading farm organizations.

The conference recommended that the governor of each state be asked to appoint a commission to study the "serious health problem which exists in many rural areas," the facilities available and to determine what additional steps are necessary adequately to safeguard the health of all citizens.

It recommended that the Farm Foundation establish a national committee on rural health by providing technical services and information and inviting the national farm organizations to name official representatives. It was recommended that the committee consult the American Hospital Association and other professional health agencies, the U.S.P.H.S. and other interested bodies.

Scholarships for farm boys and girls to study medicine and then return to rural areas for practice were also recommended.

Nurse Recruitment Leaps at Meriden

An intensive nurse recruitment drive was staged by Meriden Hospital, Meriden, Conn., as its contribution to the town's celebration of its citation by the War Manpower Commission as the "ideal war community." In addition to an exhibit of the hospital's work, Dr. Herbert T. Wagner, director of the hospital, helped arrange an assembly of 600 girl pupils of Meriden High School at which Mary O. Jenney, nurse educational consultant on the staff of the U. S. Cadet Nurse Corps, was principal speaker. Doctor Wagner also presented two student nurses, one in regulation nursing uniform and the other in cadet corps uniform. As a result of this program, Doctor Wagner reports that applications for the school of nursing are coming in at a materially increased rate.

Army Designs Ambulance

Built on a truck chassis with special springs and designed for use in general hospitals in this country, a new type of ambulance has just been announced by the Army medical department. Interior features of the ambulance include a special insert for litter holders and special arms on each side for the litters. A metal equipment box in the rear, below floor level, for carrying instruments is dustproof and water-tight.

Five Universities Announce Workshops in Nursery Problems

A two weeks' workshop in problems relative to the administration of college programs in nursing will be conducted at the Catholic University of America beginning June 12. The instruction will be given by the faculty of the university's school of nursing education and by visiting consultants. Problems that will be discussed in the course of the workshop include organization, curriculum and clinical instruction and experience.

Other universities that are planning workshops in nursing problems, and the dates, are the following:

University of California School of Nursing, Berkeley. Definite dates have not been set but it will be held in May or June.

Columbia University, Teachers College, Division of Nursing Education, May 29 to June 9. A two weeks' course on materials and methods of head nurse education will be conducted by Mrs. R. Louise McManus and assistants.

Duquesne University School of Nursing, July 3 to 14. Practical problems to be studied are: selection, admission and rotation of students and administration of the cadet corps program.

Incarnate Word College, Department of Nursing Education, San Antonio, Tex., May 24 to 30.

Underground Military Hospital Is Functioning Somewhere in England

Somewhere in England there is a military hospital with accommodations for 400 patients 70 feet below ground. The ingenious institution was constructed by a tunneling company of Army engineers in three months' time.

The subterranean hospital also includes dormitories for doctors and orderlies, an operating theater, kitchens, administrative offices and dining and rest rooms. Nearly 1000 yards of galleries and chambers are kept fresh by one of the most up-to-date air-conditioning plants in the country.

The construction of hospitals that are as nearly bombproof as possible was considered desirable inasmuch as approximately 500 British hospitals have suffered severe structural damage or outright destruction from enemy bombs from the beginning of hostilities up to and including August 1943.

Medical Prepayment by 3,000,000

More than 3,000,000 persons are eligible for medical services in the 129 medical prepayment plans in the United States described in Bureau Memorandum No. 55, recently published by the Social Security Board. The bulletin was prepared by Margaret C. Klem and attempts to present data on all prepayment medical plans in the United States and a few in Canada. The data were gathered by correspondence and personal interviews and relate mainly to the first half of 1943. Commercial insurance and industrial plans providing cash benefits only were not included.

Fosdick Urges International Fight on Air-Borne Disease

A medical League of Nations to protect the world from air-borne and airplane-borne epidemics is immediately necessary, Raymond D. Fosdick declared in his annual report as president of the Rockefeller Foundation.

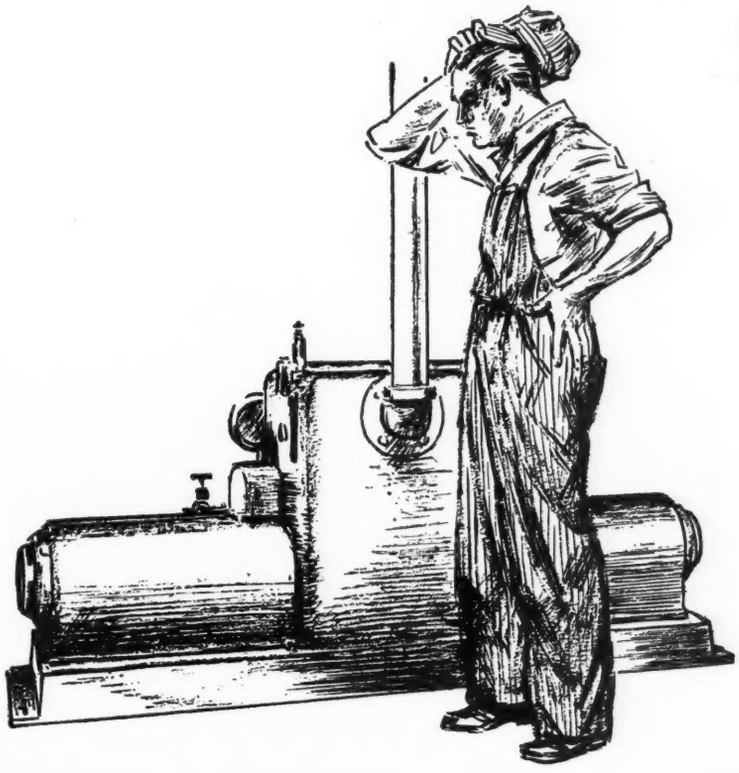
Mr. Fosdick cited the recurrence of malaria in Brazil after its extermination in 1940 because of the importation of mosquitoes by planes from Africa. "The safety of the Western Hemisphere can no longer be left to the uncertainties of a flit-gun campaign. Whether it is malaria or yellow fever or typhus or bubonic plague, the nations of the world face these enemies of mankind not as isolated groups behind boundary lines but as members of the human race living suddenly in a frightening propinquity. Some kind of regularized international cooperation is essential."

Mount Sinai Announces Postwar Development Program

Col. George Baehr and Dr. Isidore Snapper have been selected to fill the newly created posts of director of clinical research and director of graduate medical education at Mount Sinai Hospital, New York City, it was announced recently. The creation of the new positions is a part of a far-reaching program of expansion by the hospital to prepare for postwar responsibilities.

In announcing the appointments, Waldemar Kops, acting president of Mount Sinai, stated that later steps in the expansion program will include enlargement of the hospital's clinical and laboratory facilities and the establishment of a number of full-time paid fellowships for young physicians and research workers.

Colonel Baehr, former president of the hospital's medical board, recently resigned as chief medical officer of the Office of Civilian Defense to return to Mount Sinai and Columbia University, where he is clinical professor of medicine. Doctor Snapper, distinguished Dutch scientist, was formerly on the faculties of the University of Amsterdam and the University of Peiping, and more recently medical adviser to the government of the Netherlands West Indies.



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2. Examine piping for "short circuit," i.e., connections that permit steam to pass directly into the returns instead of through the drip trap. Check recent piping changes.
3. Make sure drip traps are operating properly. Check drip points of steam heaters, hot-water generators, mains and risers.
4. Clean priming boilers. Excessive water carried over with the steam keeps drip traps open and prevents building up vacuum.
5. Tighten or replace packing of radiator valves which allow air to leak into the system.
6. Re-evaporation from high pressure condensate discharging into low pressure returns can prevent maintenance of vacuum. Flash tank and float trap arrangements will generally correct this.

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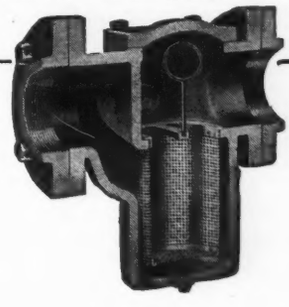

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Merchant Fleet Carries Hospital Corpsmen Now

Trained hospital corpsmen are sailing aboard freighters and tankers of the merchant fleet for the first time in the history of the United States, it was revealed recently. To compensate for the shortage of doctors available for this service, a U. S. Maritime Service Hospital Corpsman School was instituted at Sheepshead Bay, N. Y.

Qualified men first receive five weeks of "boot" training and then undergo a twelve weeks' course in anatomy, physiology, hygiene and sanitation, first-aid emergency treatment, nursing, pharmacy and clinical laboratory.

Because they have to double as pursers in the merchant marine, the men next receive training to keep the ship's records. Then they are graduated to assignment of a four weeks' duty in a Marine hospital. They are ready for sea duty upon completion of the entire twenty-seven week course and serve as junior assistant pursers and pharmacist's mates.

Charity "Out" for Army Wives

Wives of servicemen who are eligible to receive benefits under the maternity care program may receive free treatment at any hospital in Cook County, Illinois, except Cook County Hospital, which is a charity hospital. This ruling by Attorney General George F. Barrett was in response to a request of Dr. Roland R. Cross, director of the State Department of Public Health, who reported that Cook County Hospital had made application to participate in the federal program.

Emergency Unit at Walter's Hospital

Frank J. Walter, president of the American Hospital Association and administrator of St. Luke's Hospital, Denver, on April 6 was presented with a certificate by the U. S. Public Health Service in recognition of the fact that his institution has formed an affiliated hospital emergency unit. Dr. W. W. Haggart, chairman of the Emergency Medical Service, O.C.D., Colorado, will be director of the affiliated unit, which is the first to be organized in the Seventh Service Command.

Lancaster Raises $806,299

Successful completion of its building fund campaign, with a total of $806,299, was announced recently by Lancaster General Hospital, Lancaster, Pa. The fund will be used for the construction of a new 100 bed wing, a new nurses' home and additions to a number of hospital departments. Work on the project will start as soon as conditions permit. More than 1500 solicitors took part in the campaign which was directed by Ketchum, Inc., of Pittsburgh. Ray B. Hall is superintendent of the hospital.

Accounting Institute Faculty and Subjects Are Announced

Members of the faculty of the A.H.A. accounting institute to be held at Indiana University School of Business, Bloomington, during the week of June 26 were announced last month. They include Prof. Stanley Pressler, director of the institute, George Bugbee, Graham Davis, Frank Luma, Fred Munsey, L. Hehmann, Harry Dunham, M. Ray Kneifl, Charles H. Pimlott, Harold Burr, Edgar Blake.

Major subjects to be presented include: hospital organization from the standpoint of accounting, admission of patients and accounting for income from patients, accounting for expenditures, including stores control, financial and statistical statements and departmental operating reports, aspects of cost accounting in hospitals, organization of the accounting department and internal controls, patients' accounts receivable control, credits and collections, pay-roll procedure and control in relation to withholding tax and other deductions, budgets and budgetary control.

New Medical Magazine Issued

The first issue of *General Practice Clinics* appeared recently. It is planned for the general practitioner "to present clearly and authoritatively all of the essential information so vital to successful diagnosis and treatment." Methods and views of several specialists in the same field are presented simultaneously for reference and comparison. It covers general medicine and surgery, obstetrics and gynecology, pediatrics, dermatology, urology and otorhinolaryngology. The magazine will appear bi-monthly and carries no advertising. Each issue has a cross-reference subject; an author index and a cumulative index will appear annually in July. It is published by the Washington Institute of Medicine, Washington, D. C.

Use Care in Selecting Volunteers

Extreme care in selecting, training and assigning volunteers was urged in a recent bulletin issued by Oliver G. Pratt, chairman of the A.H.A. committee on men volunteers. Recently, Mr. Pratt stated, it was claimed that the loss of narcotics in an eastern institution was due to a volunteer. He pointed out that with the thousands of volunteers working in hospitals it is natural to expect a certain number of such unfortunate episodes and that hospitals must take every possible precaution to guard against them.

Three Hospitals Report on Year's Activities

Especially attractive hospital reports were published during March by Hurley Hospital, Flint, Mich., Wyandotte General Hospital, Wyandotte, Mich., and Wesley Memorial Hospital, Chicago.

The Hurley report was prepared as part of the program announcing the opening of the eleventh floor addition to the main building of the hospital and contains a history of the hospital since its beginning in 1905.

The Wyandotte report is dedicated to the medical and surgical staff, graduate nurses, technical and nonprofessional workers and volunteers. Artistic full-page illustrations are extensively used.

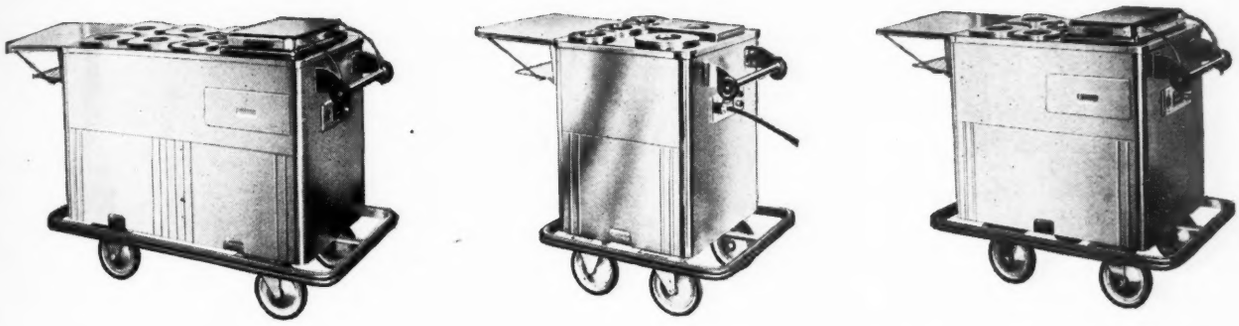
The Wesley report opens with a pictorial description of three activities influenced by the war: the cadet nurse corps, accelerated medical education and volunteer services. A total of 63,396 hours of volunteer service for 1943 is reported. They were given by nurse's aides, Gray Ladies, canteen workers, A.W.V.S., victory volunteers, Methodist Church women's groups, Jangoes and men volunteers.

Rural Virginia Needs Hospitals

The lack of hospital facilities and medical care in the rural areas of Virginia is "one of our most pressing problems," declared Gov. Colgate W. Darden Jr. in his message to the legislature. He recommended that the advisory council study this problem and the problem of extending hospital prepayment to rural areas and present proposals to the next session of the legislature. He also recommended establishment of a psychiatric institute for research in the field of mental diseases and new buildings for many of the state hospitals for mental disease.

Educational Background Improves

The proportion of college alumnae among nursing students has doubled in the last ten years, it was revealed in a report on the educational qualifications of student nurses made by the department of studies, National League of Nursing Education. The study shows that of 92,762 students in 1008 schools all had completed high school and 13.3 per cent, or 12,400 students, also had had some college work before beginning their nursing studies. Of these 12,400, 8 per cent had attended college for one year; 4 per cent, two years, and 1 per cent, three or four years.



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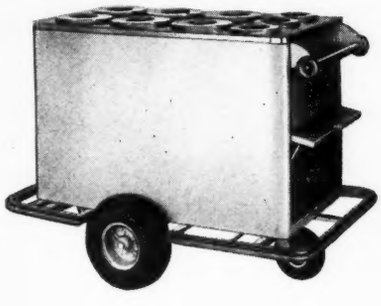

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O.D.T. Again Urges Canceling of Unnecessary Conventions

WASHINGTON, D. C.—Joseph B. Eastman, late director of the Office of Defense Transportation, shortly before his death on March 15, appealed to organizations to cancel annual conventions which will not help to shorten the war. Even a close relation to the war effort, Mr. Eastman said, does not justify the added strain placed on trains, buses, hotels and many other civilian services.

In March, O.D.T. adopted a plan of the Philadelphia Convention and Tourist Bureau designed to discourage all conventions not directly related to the war effort. Under the Philadelphia plan, O.D.T. will be informed at once of all convention arrangements, and no hotel reservations for conventions will be made more than thirty days in advance.

Another stipulation of the plan is to discontinue for the duration of the war active solicitation of convention business except those to be held in the postwar period or those qualifying as war conferences.

Reforms in Mental Disease Hospitals

Eleven bills to reform the mental disease hospitals of New York State were signed by Gov. Thomas E. Dewey on April 11. The measures deal with boards of visitors, accounts and records of hospitals, licenses of examiners and psychologists, and records of patients. They represent a substantial part of the program developed by the Moreland Commission, headed by Archie Dawson, which investigated the administration of state institutions under the jurisdiction of the department of mental hygiene.

Million for Physical Therapy

Bernard M. Baruch has donated the sum of $1,000,000 for the development of physical medicine, it was announced on April 27. He stipulates that the war wounded be given particular attention. A single committee will control five individual programs of physical therapy study.

Foundation to Aid Pharmacy Colleges

Directors of the American Foundation for Pharmaceutical Education voted on April 4 to establish a fund of $100,000 to aid colleges of pharmacy whose income has been drastically cut by wartime reduction in enrollments. The allotment will come out of $421,925 in contributions that have come to the foundation to date. In the first year of its existence the foundation has granted $200 scholarships to 124 students at 62 colleges of pharmacy. A second award of 128 scholarships is now under consideration by the board of grants.

Army Hospital to Open in June

Patients will be received at Vaughan General Hospital, new Army hospital at Hines, Ill., between June 1 and 15, it has been announced by Brig. Gen. Percy J. Carroll, commander. General Carroll revealed that the hospital includes 57 separate buildings and six more will be added by late fall. It will have 1550 beds and a personnel of 1350, about half of whom will be civilians. The $5,000,000 hospital will handle all types of cases. Patients will be soldiers from overseas who live in the surrounding area.

Community Hospital Planned

Pledges totaling more than $22,000 have been received for the erection of a community hospital at Princeton, Minn. The goal set for the building and equipment of the hospital is $75,000 and incorporation papers will be drawn up when $25,000 has been obtained. According to the plans of the building committee, the institution will be managed by a board of directors to be elected by members of the hospital association. Membership will be granted to persons who pay $100 into the project.

Uncle Sam wants you to have modern equipment for *efficient* mass feeding

The U. S. government clearly recognizes the vital importance of food and nutrition on the home front—as an essential part of the nation's war effort. This is particularly true where feeding of war workers is involved. But it also applies to all mass feeding including hospitals, hotels and institutions. For in total war the health and efficiency of every individual is important.

Accordingly, the War Production Board has set up provisions and conditions whereby modern equipment which contributes to greater efficiency in mass feeding, including heavy duty ranges, can be provided.

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Group Practice a Postwar Need, Kaempffert Declares

City hospitals should take the burden of free medical care from voluntary hospitals and the research work of both should be integrated and expanded.

This is the opinion of Waldemar Kaempffert, science editor, *New York Times,* as expressed before the annual meeting of the New York City Visiting Committee of the State Charities Aid Association held in New York.

Mr. Kaempffert sees the days of generous giving by which voluntary hospitals make up their deficits as about over, with the result that city hospitals must assume a greater share of the burden. He also sees a trend toward the establishment of group practice providing the services of specialists and the latest scientific equipment.

Dr. Edward M. Bernecker, commissioner of hospitals, New York City, indicated that the city's postwar program included five new general hospitals with a bed capacity of 500 each. These have been planned with community practice in mind.

New York as World Medical Center

Postwar New York will become a world center for advanced medical training, it was predicted by Dr. Arthur F. Chace in his final report as president of the New York Post-Graduate Medical School and Hospital. Calling attention to the fact that physicians from 38 states and one territory of the United States and from 12 foreign countries had enrolled last year for postgraduate training, Doctor Chace declared: "We have every reason to believe that after the war medical men of all the world will look to America for leadership." Doctor Chace asserted that the whole plan of medical education is being revolutionized to meet two important changes: first, the rapid advances in medical science, and second, the fundamental change in our social attitudes.

Hospital Plans to Rebuild

Charles F. Kettering, vice president of General Motors and honorary president of Miami Valley Hospital, Dayton, at the hospital's recent annual meeting, revealed plans of the hospital to rebuild in the form of a health center devoted to research and the prevention of disease. A total of more than $2,000,000 has been raised to build a new hospital but work was stopped by scarcities of materials. "It was a lucky thing we were delayed," said Mr. Kettering, "because we will get a better hospital than we would if we built it now."

Cornell Repeats Refresher Course

Fundamentals of hospital operation will be presented from both the theoretical and practical points of view at the two week refresher course in hospital administration to be offered at Cornell University from July 3 to 15. Enrollment in the course is limited to administrators, superintendents of nurses, dietitians, executive housekeepers and other hospital executives. Dr. Joseph C. Doane, Jewish Hospital, Philadelphia, and Dr. Donald Smelzer, director of Germantown Hospital and Dispensary, Philadelphia, will conduct the course.

Occupational Therapists Needed

As more injured soldiers return to hospitals, more occupational therapists are needed to aid in their adjustment in normal life, the Civil Service Commission reports, in announcing that appointments for occupational therapists are now open in Army and Veterans' hospitals. The greatest need is for experienced graduates of accredited occupational therapy schools. Other positions will be filled by inexperienced graduates of such schools. Salaries range from $1970 to $2433 per year, including overtime pay. There are no age limits and no written tests, but applicants must be physically able to perform the duties.

ABOUT PEOPLE

(Continued From Page 70)

appointed executive secretary of the Oklahoma State Medical Association, Oklahoma City.

Richard O. West, formerly assistant director New Haven Hospital, New Haven, Conn., has been appointed director at Portsmouth Hospital, Portsmouth, N. H. Mr. West succeeds **Rosanna O'Donoghue,** who resigned after twenty years of service. Miss O'Donoghue was a member of the board of directors of New Hampshire Hospitalization Service when it was inaugurated and is widely known in hospital circles in New England.

E. Vera Dean has been appointed superintendent, W. B. Plunkett Memorial Hospital, Adams, Mass., replacing **Gladys Rudisill** who was recently married. Miss Dean was formerly superintendent, Morrison Hospital, Whitefield, N. H.

Department Heads

Don C. Francke has been named chief pharmacist of University Hospital, Ann Arbor, Mich., succeeding **Harvey A. K. Whitney.** Mr. Francke, who is chairman of the American Society of Hospital Pharmacists, was formerly assistant to Mr. Whitney. Recently, he has been studying for his doctor's degree at Purdue University.

Sister Mary Louis Wenzl, O.S.F., formerly floor supervisor and more recently acting director of St. Joseph's School of Nursing, Omaha, has been appointed director of nurses at St. Anthony's Hospital, Denver.

Janet Korngold, director of nurses at Fresno County General Hospital, Fresno, Calif., on June 1 will become director of nurses at King County Hospital, Seattle. Prior to her association with Fresno Hospital, Miss Korngold had been head of the nursing departments at St. Luke's Hospital in Chicago and at Touro Infirmary, New Orleans.

Allen H. Mathewson has been appointed purchasing agent of Massachusetts General Hospital, Boston. He has been assistant purchasing agent since 1940.

Adeline Wood, dietitian at Mount Sinai Hospital, New York City, has accepted the position of dietitian at Florida State College for Women, Tallahassee.

Miscellaneous

Dr. Thomas Parran, surgeon general of the United States Public Health Service, was nominated on March 24 by President Roosevelt to serve another four year term. Congress confirmed his reappointment. Doctor Parran has held this office since April 1936.

Lt. Mary H. McKinnon, A.N.C., has been appointed assistant to **Maj. Mary Walker,** director of the U. S. Cadet Nurse Corps. She will assist in assigning students who have completed their civilian hospital training to Army general hospitals.

Marjorie Fish, director of occupational therapy at Columbia University, has been appointed national educational field director of the American Occupational Therapy Association. The wartime emergency post that Miss Fish is assuming was created at the request of the Council on Medical Education and Hospitals of the American Medical Association, the professional and technical division of the War Manpower Commission and the occupational therapy branch and reconditioning division of the Surgeon General's Office of the Army.

Ruth Sleeper has been appointed special consultant in the Division of Nurse Education, U. S. Public Health Service. On leave of absence from her position as assistant to the director of Massachusetts General Hospital School of Nursing, Boston, Miss Sleeper will make a month's study of schools of nursing in South Carolina.

Dr. H. M. Rees, chief of the profes-

sional equipment unit, hospital section, Government Division, W.P.B., has resigned after eighteen months of service in handling hospital applications.

Gladys Hall, educational director of the American Dietetic Association, has been appointed executive secretary, succeeding **Mrs. Katherine Mitchell Johnson.** During the last year Miss Hall has been active in promoting the accelerated training program for student dietitians. **Lucille Refshauge** has been named educational director of the association.

H. P. Schwarzman, formerly director of purchases, Joint Purchasing Corporation, New York City, has resigned from that organization to become director, Hospital Purchasing Service, 50 East 43d Street, New York City.

Deaths

Gustavus A. Rogers, former president of Sydenham Hospital, New York City, died unexpectedly at the age of 67. Mr. Rogers had been active in the affairs of Sydenham for some years.

Dr. Oswald E. Denney, 59, U.S.P.H.S., medical officer in charge of the U. S. Marine Hospital, Galveston, Tex., and chief quarantine officer, died recently. Doctor Denney was the first medical officer in charge of the U. S. Marine Hospital, Carville, La., after its purchase by the government in 1921 when it became the National Leprosarium. He remained at Carville until 1935.

Mary A. Foley, formerly consultant dietitian of the Mayo Clinic and well known in the dietetic field, died in Worcester, Mass., at the age of 57. Miss Foley had held important dietetic posts including one at Massachusetts General Hospital, Boston, where she served as chief dietitian from 1921-23.

Peter G. Lehman, first lieutenant in the U. S. Army Air Corps, and for six years a member of the board of trustees of Montefiore Hospital, New York City, was killed March 31 during acrobatic maneuvers over his home base somewhere in England. The son of Herbert H. Lehman, the director general of U.N.R.R.A., Lieutenant Lehman had participated in 57 missions and held the Air Medal with three oak leaf clusters.

Trustees

Mrs. Frederic F. deRham, Frederick A. O. Schwarz and **William J. Wardall** have been elected to the board of managers of Presbyterian Hospital, New York City. Both Mr. Schwarz and Mr. Wardall have been members of the Society of the Presbyterian Hospital. Mrs. deRham has served on the board of women managers of the Babies Hospital since 1922.

Coming Meetings

May 8-14—War Conference on Industrial Medicine, Hygiene and Nursing, Hotel Jefferson, St. Louis.

May 10-12—Tri-State Hospital Assembly, Palmer House, Chicago.

May 11-13—New Jersey Hospital Association, Hotel Claridge, Atlantic City.

May 14-16—Minnesota Hospital Association, St. Paul Hotel, St. Paul.

May 17-18—Carolinas-Virginias Hospital Conference, Battery Park Hotel, Asheville, N. C.

May 22-25—Catholic Hospital Association, St. Louis.

May 22-26—Canadian Medical Association, Royal York Hotel, Toronto, Ont.

May 24-26—Hospital Association of New York State, Buffalo.

June 1-2—National Executive Housekeepers' Association, Bellevue-Stratford Hotel, Philadelphia.

June 6-8—American Nurses' Association, National League of Nursing Education, National Organization for Public Health Nursing, Hotels Statler, LaFayette and Buffalo, N. Y.

June 12-16—American Medical Association, Palmer House and Stevens Hotel, Chicago.

June 20-22—Maritime Hospital Association, Admiral Beatty Hotel, St. John, N. B.

June 26-30—Canadian Nurses' Association, Winnipeg, Man.

Aug. 25-26—Institutional Laundrymen's Association, Bellevue-Stratford Hotel, Philadelphia.

Oct. 2-6—American Hospital Association, Hotels Statler and Cleveland, Cleveland.

Oct. 3-5—American Public Health Association, Hotel Pennsylvania, New York City.

Oct. 23-27—American College of Surgeons Clinical Congress, Stevens Hotel, Chicago.

Oct. 25-27—American Dietetic Association, Palmer House, Chicago.

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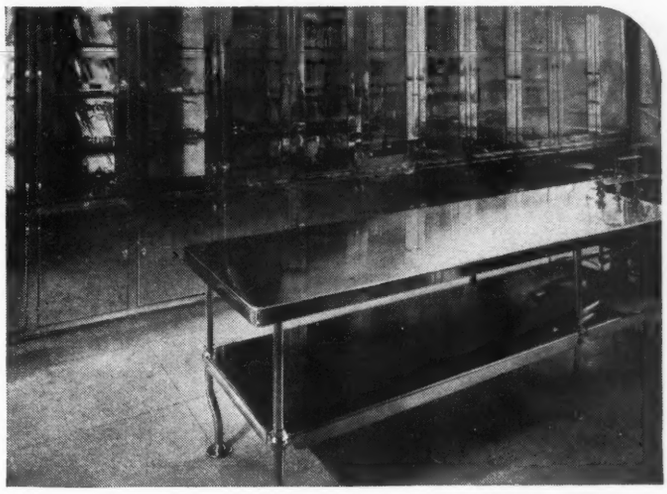
meets modern surgical requirements

● Nowhere in a hospital are requirements so exacting, or equipment subject to such severe usage, as in the operating room. That is why an ever-increasing number of hospitals want the advantages of wear-resistant, rust-proof stainless steel for surgical instruments, instrument stands and cabinets, and the tops of operating tables, where safe surgical practice requires surfaces that will not chip or peel.

The smooth, bright surfaces of stainless steel are unaffected by heat or the strong antiseptics employed. Equipment can be sterilized again and again without injury, and is inexpensive considering its long service life. It will pay you to consider the advantages of this lasting metal for your equipment.

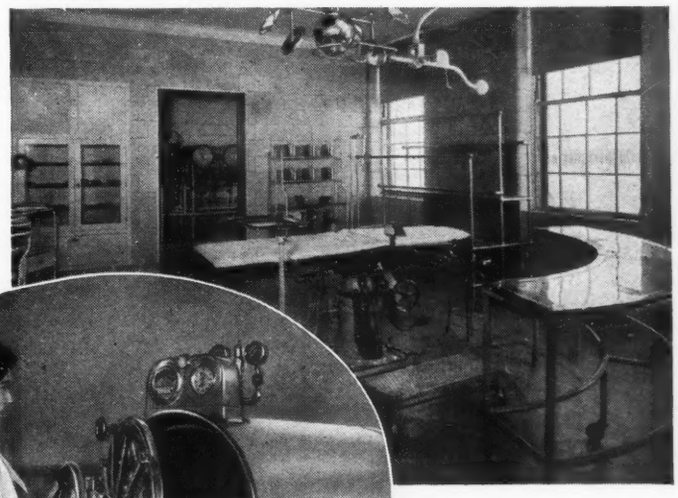
Although we do not make stainless steel, we have for over 35 years produced Electromet ferro-alloys used in making steel. With the knowledge accumulated from this experience, we are in a position to give you impartial assistance in the selection of a stainless steel for your particular needs. Your request for this service involves no obligation.

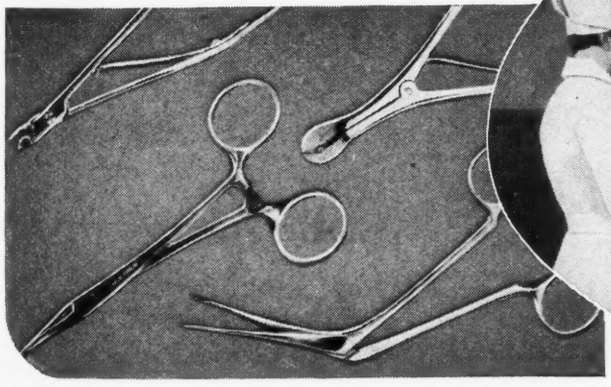


Above: Stainless steel equipment helps to insure cleanliness and sanitation in this modern instrument room.

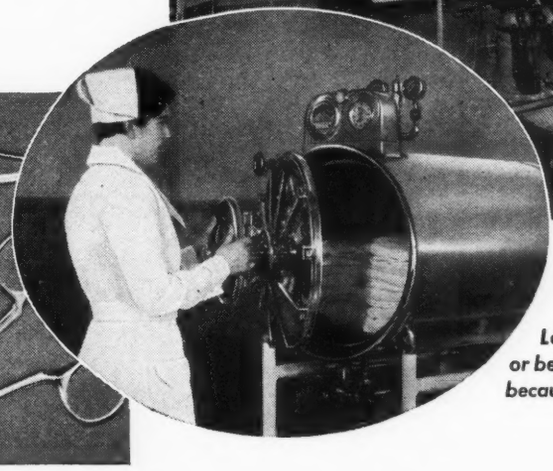
★

Below: The corrosion resistance of stainless steel makes it ideal for operating-room equipment.





Surgical instruments of stainless steel are strong, readily sterilized, and non-tarnishable.



Left: This autoclave will not rust or be affected in any way by steam, because it is made of stainless steel.

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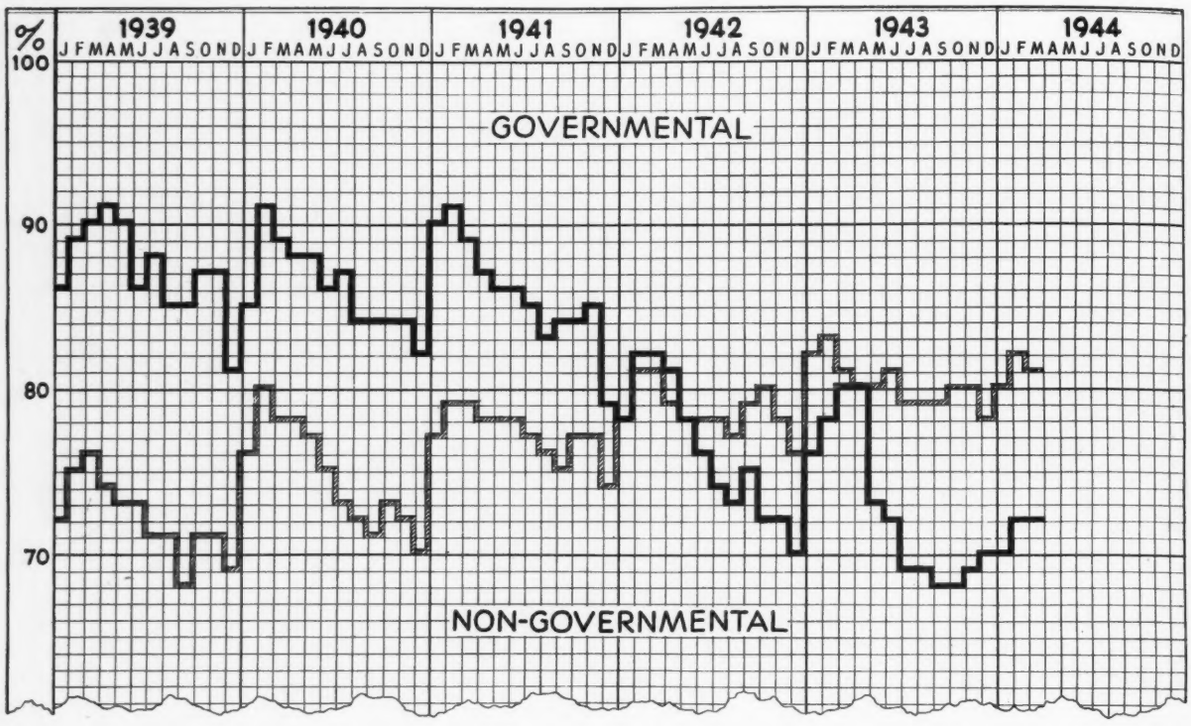
Governmental Hospital Occupancy Continues Low



Occupancy dropped off slightly in March in the nongovernmental hospitals from the February level but in the governmental hospitals remained at the same spot. The contrast with last year's figures is quite marked for the latter group.

Seventeen new construction projects were reported from March 20 to April 17. Fourteen gave costs which totaled $6,640,000. That brings the year to date total to $31,484,000 as compared with $37,831,000 last year. Of the projects reported in the last month, nine were additions to hospitals.